Tri-City Helping Hands Services

TRANSPORTATION REQUEST FORM

Please complete this form and return to Tri-City Helping Hands Services as part of the intake process or upon request.

CLIENT NAME: ____

ADDRESS: ____

PHONE NUMBER: ____

DAYS OF SERVICE (CIRCLE ALL THAT APPLY) M T W TH F SA SU

SPECIAL NEEDS OF CLIENT (CIRCLE ALL THAT APPLY) Wheelchair Walker Other

Other: ____

Can client be dropped off at home if no one else is present? (check which applies):

Y es ____ N o____

Special Instructions for pick up/drop off:

____

Is the client subject to (circle any that apply): Seizures?
Wondering?

OTHER:

____

Once the application is processed, Tri-City will contact client and/or caregiver to arrange pick up and drop off times.

If transportation is to be cancelled for weather reasons, notification will be reported to Channel 5 News.

SIGNED: ______________________________________ DATE: ______________

RELATIONSHIP TO CLIENT: SELF FAMILY CAREGIVER GUARDIAN OTHER

DATE SERVICES STARTED: ________________________________

DAYS ATTENDING: _____________________________________

TRANSPORTATION: ___________________________________ PHONE NUMBER: ________________

Allergies: ____
____

Special concerns: ____
____

AUTHORIZED PERSONS FOR PICK UP

The following persons are authorized to pick up ________________________________ from Tri-City Helping Hands Services.

#1 Name: _________________________________ Relationship: ___________________________

Home phone: _______________________ Cell phone: _________________

#2 Name: _________________________________ Relationship: ____________________________

Home Phone: _______________________ Cell phone: _________________

#3 Name: _________________________________ Relationship: ____________________________

Home Phone: _______________________ Cell Phone: _________________