Town of West Hartford Dial-A-Ride Medical Access Program (MAP) Application

July 1, 2024 to June 30, 2025

MUST BE RENEWED SEMI-ANNUALLY

Eligibility

This supplemental application is for all members who have an urgent ongoing need for medical transportation such as dialysis, chemotherapy, or similar medically necessary treatment that will need more than 3 round trip rides per week.

Applicant Information

Full Name: ____

(Last Name) (First Name)

Home Phone: _________________ Cell Phone: __________________ E-Mail Address: ____________________

Date of Birth: _____________________________ Preferred Language: ________________________________

Emergency Contact Information

Emergency Contact Name: ___________________________________Relationship: ______________________

Emergency Contact Phone Number: ____

Medical Provider's Certification

Medical Provider's Name: ______________________________ Phone Number: _________________________

I, ____, hereby certify that the Dial A Ride passenger named above has an urgent ongoing need for medical transportation such as dialysis, chemotherapy, or similar medically necessary treatment that will require more than 3 round trip rides per week to a medical facility.

Medical need start date: ___________________ End Date: ________________________________

Medical Facility: ____________________________________

_______________________________________ _____________________________________

(Medical Provider's signature and title) (Date)

Mail or Fax Completed form to:

West Hartford Dial-A-Ride

50 South Main St. Room 306, West Hartford, CT 06107

Fax Number: 860-561-7577

E-mail Andrea.Ruggiero@WestHartfordCT.gov

For any questions, please contact Andrea: 860-561-7560