

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

July 1, 2024 to June 30, 2025

MUST BE RENEWED ANNUALLY

Eligibility

This supplemental application is for all members who have an urgent ongoing need for medical transportation such as dialysis, chemotherapy, or similar need and due to 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 a medical condition which requires an ongoing medical need for repeat appointments such as dialysis, chemotherapy, rehabilitation or similar need.

Medical need start date: _____ End Date: _____

(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