



28710 Old North River Rd., Harrison Township, MI 48045 Phone: (586) 493-9822 Fax: (586) 493-9821

Request for Non-Emergency Medical Transportation

Recipients for non-emergency transportation at no cost is based upon: a.) the poverty guidelines updated periodically in the *Federal Register* by the U.S. Department of Health and Human Services under the authority of 42 U.S.C.9902(2); or b.) an individual's debt to income ratio matches or is greater than his or her current income. Such debts include mortgage payments, utility bills, and healthcare/insurance expenses (*documentation required*). Additional qualifying criteria include: the physical inability to drive; lack of a vehicle or other form of reliable transportation (i.e., friend, family member, or caretaker); or lack of a handicapped equipped vehicle. In some situations under special circumstances, exceptions to the aforementioned criteria may be made up to the discretion of PHOA management. In order to substantiate that recipients indeed qualify for free transportation service, it is required that the following documents be submitted to PHOA: current bank statements; current utility bills; current income statements (paycheck stub or W2); receipts or other proof of medical expenses; and a medical needs form completed by a tending physician, as well as a medical release form.

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Emergency Contact Name _____ Relationship _____

Phone _____ Alternate Phone _____

Please answer the following questions:

1. For what type of medical service do you need transportation? Please circle all that apply.

Doctor's Appointment Physical Therapy Chemotherapy Dialysis Lab Work Other _____

2. Where is the medical service located? If you are in need of transportation for more than one service, please list each location.

Location #1

Name/Address _____

Phone Number _____ How often do you need transportation? _____

Location #2

Name/Address _____

Phone Number _____ How often do you need transportation? _____

Location #3

Name/Address _____

Phone Number _____ How often do you need transportation? _____

Please circle Yes or No for the following questions:

3. Do you own a vehicle? No Yes

4. Do you have someone who can help you with transportation (i.e., relative, friend, or caretaker)?

If yes, who? No Yes _____

5. Do you have a valid driver's license? No Yes

6. Are you physically able to drive? If no, please explain.

No _____ Yes

7. Do you need to use a handicapped equipped vehicle for your transportation need(s)? If yes, please explain.

No Yes _____

8. Are there any special circumstances of which we should be aware?

9. For scheduling purposes, when are you available for your medical appointment(s)? Please circle the days you are available and write in the times on the line next to each day.

Monday _____ Tuesday _____ Wednesday _____ Thursday _____
Friday _____

10. What is your gross (before taxes) income per month? Please list all sources of income (i.e., employment, disability, social security, worker's compensation, unemployment, pension/retirement, veteran's benefits, cash assistance through Department of Human Services, alimony, etc.)

11. If you make a monthly mortgage or rent payment, what is the amount of that payment? _____

12. What is your monthly cost for the following?

Gas _____ Water _____ Electricity _____ Phone _____

Food _____ Medical bills (medication, supplies, at-home care, insurance, etc.) _____

13. If you have health insurance, please provide the following:

Provider Name _____ Provider Phone _____

Member Number _____ Group Number _____

14. Where did you hear about People Helping One Another? _____

I hereby authorize People Helping One Another (PHOA) and its representatives to contact my healthcare provider(s) for the purpose of scheduling transportation. I understand that my personal healthcare information is protected under the HIPAA Privacy Act and I have been given a copy of my rights under the Act. I further authorize PHOA to review and verify my income and expense information, as well as all other information provided.

Signature _____ Date _____

Witness _____ Date _____

People Helping One Another will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, sexual orientation, gender identity or expression, political beliefs, or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a PHOA staff member.

You May Contact us at: (586) 493-9822

Office Use Only:

Reviewed by: _____

Proof of income: _____

Proof of housing expense: _____

Proof of utilities: _____

Proof of medical expense: _____

Other: _____

