

**Municipal Medical Transportation Service
East Lyme, Groton, New London, Stonington, Waterford
SELF REFERRAL ELIGIBILITY FORM**

Name:(please print) _____ Birth Date ____/____/____

Address: _____

City _____ Zip Code _____

Telephone # _____

Please describe your home's exterior _____

Is the house number on the house or mailbox? _____

Do you have a physical disability? Circle one. **Yes** **No**

Do you have a mental disability or cognitive impairment? Circle one. **Yes** **No**

Do you have Medicaid as a form of insurance? **Yes** **No**

Note: Individuals under the age of 60 must provide proof of their disability from the Social Security Administration.

Do you use a mobility aid? i.e. wheelchair, walker, cane, scooter? Please list.

Can you get into a car unassisted? Circle **ONE!** **Yes** **No**

Emergency Contact information:

Name _____

Address _____

Telephone # _____

Please mail or deliver the completed form to your senior center:

- *To minimize abuse, all trips are subject to random audit.*
 - *Service is not available to Nursing Homes.*

We reserve the right to deny transportation to any individual who does not meet the criteria for the transportation program.

I have read and understand the guidelines of the municipal medical transportation service, which is attached.

Client Signature

Date

