CUYAHOGA COUNTY BOARD OF HEALTH
YOUR TRUSTED SOURCE FOR PUBLIC HEALTH INFORMATION

Cleveland Transitional Grant Area- Ryan White Part A

Medical Transportation Form

1. Service Date: _____

2. Client Name: _____ **3. CAREWare ID:** _____

4. Was the client screened for other available resources for transportation services? ☐ Yes ☐ No

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5. Form Directions- Check the box (**A. – D.**) for the type of assistance provided and complete related fields.

*Services Accessed- Funds may be used to provide transportation services to an eligible client to access HIV-related health services, including services needed to maintain the client in HIV/AIDS medical care.

☐ **A. Public Transportation**

Service(s) Accessed*	Date(s)	Type of Bus Pass	Quantity	Pass/Voucher Number(s)
		RTA Daily Bus Pass ($5.00)		
		RTA Daily Bus Pass- Disabled ($2.50)		
		Other RTA Bus Pass ($_____)		
		RTA ID Voucher- No value until exchanged for RTA ID	N/A	

☐ **B. Fuel Card/Mileage Reimbursement** **OR** ☐ **C. Cab/Taxi Voucher**

Service(s) Accessed*	Miles	Date	Starting Address	Destination Address

Service(s) Accessed*	Miles	Date	Starting Address	Destination Address

Service(s) Accessed*	Miles	Date	Starting Address	Destination Address

Service(s) Accessed*	Miles	Date	Starting Address	Destination Address

Total Miles: _____ **Total Fuel Card/Mileage Reimbursement or Taxi/Cab Voucher Amount: $_____**

☐ **D. Parking Voucher**

Service(s) Accessed*	Date(s)	Quantity

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____