



P.O. Box 1978
Salisbury, MD 21802-1978
410-749-1015 - (Fax) 410-749-1020

Dear TLC Patient ~

All patients needing transportation will go through an eligibility process. To enable us to implement this new process, please complete the application and any other pertinent forms explaining how your disability prevents you from driving or riding public transportation systems. An in-person interview may be necessary to formally determine your eligibility for the program.

All transportation is to be scheduled 48 hours in advance. For patients speaking a language other than English, an interpreter will be available to assist you. If you do not qualify for our transportation service, a letter will be mailed to you explaining the reason.

If you have any questions, please call 410-651-9852, Extension 1304.

Sincerely,

TLC Management



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Are You Eligible for TLC Transportation?

1. Are you able to get to and from the bus stop close to where you live?
Yes _____ Sometimes _____ No _____
2. With help from the bus driver, are you able to get on and off a bus?
Yes _____ Sometimes _____ No _____
3. With the help from a bus driver who announces major bus stop and transfer points, are you able to figure out the right bus stop?
Yes _____ Sometimes _____ No _____
4. Can you transfer from one bus to another bus?
Yes _____ Sometimes _____ No _____
5. How do you get to and from the grocery store? _____
6. What type of insurance(s) do you have? _____
7. Are you in a wheelchair? _____ Do you walk with a cane/walker? _____
8. Do you have a current disability that would prevent you from riding the public transportation bus (Shore Transit)?

9. Do you or anyone in your household have a vehicle? _____



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TRANSPORTATION APPLICATION

Instructions For Completing This Application~

- √ Be sure to read the enclosed information and complete.
- √ All questions must be answered. Incomplete forms may delay processing your application.
- √ If you have any questions or need assistance in completing this form, please contact the TLC Case Manager.

Client's Name: _____
Last First Middle

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Daytime phone: _____ Evening phone: _____

Date of Birth: _____ Emergency Contact Person: _____

Emergency Contact Relationship: _____ Phone: _____

For Office Use Only

Received By: _____

Date Application Received: _____ Approved: _____ Denied: _____

Date Health Care Provider Information Received: _____

Conditional Eligibility: _____

Nearest Major Intersection: _____

Nearest Bus Stop: _____

Approximate Distance to Nearest Bus Stop: _____

Other Information: _____



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Estimado paciente de TLC:

Todos los pacientes que necesiten transportación tendrán que cumplir con un proceso de elegibilidad para recibir la transportación. Por favor complete la aplicación y cualquier otro formulario que ayudaría a determinar las razones por la cual su discapacidad le impide a conducir un automóvil o usar la transportación pública. Una entrevista en persona tal vez sea necesaria para formalmente determinar si usted califica para el programa.

Todas las citas de transportación serán hechas con 48 horas de anticipación. Para los pacientes que no hablan inglés, se le proveerá un intérprete para asistirle. Si usted no califica para nuestro servicio de transportación, se le enviara una carta explicándole la razón.

Si usted tiene cualquier pregunta, por favor llame al 410-651-9852 y elija la extensión 1304.

Sinceramente,

La Gerencia de TLC

Es usted elegible para la transportación de TLC?

1. ¿Puede usted ir y regresar a una parada de autobús que este cerca de donde usted vive?

Si _____ A veces _____ No _____

2. ¿Si el chofer le ayuda, pudiera usted subirse y bajarse del autobús?

Si _____ A veces _____ No _____

3. ¿Si el chofer le ayuda con anunciar las paradas importantes y los sitios de transbordar, pudiera usted descifrar la parada correcta?

Si _____ A veces _____ No _____

4. ¿Pudiera usted transbordar de un autobús a otro autobús?

Si _____ A veces _____ No _____

5. ¿Cómo va usted a la tienda para hacer compras? _____

6. ¿Qué tipo(s) de seguro(s) medico tiene usted? _____

7. ¿Esta usted en una silla de ruedas? _____ ? ¿Usa usted un bastón o andador para caminar? _____

8. ¿Tiene usted una discapacidad actual que le impide a montarse en el autobús de la transportación publica (Shore Transit)?

9. ¿Tiene usted o hay alguien en su hogar que tenga un automóvil?

Case Manager – Health Care Professional Verification

Patient's Name: _____

1. Does the individual have a functional or cognitive disability that can be documented?
 Yes No If no, please complete the signature section and fax back.

2. What is the condition causing the disability? _____

3. What is the expected duration of the disability? _____

4. What mobility aids does the individual currently use?
 Manual Wheelchair Powered Scooter Portable Oxygen
 Powered Wheelchair Walker Cane White Cane
 Crutches Other; please specify _____

5. Please indicate the individual's ability to independently perform the following functions using the most effective mobility aid:

	Little or no Difficulty	Discomfort and/or inconvenience	Severe pain and additional impairment	Impossible or likely to cause a serious medical Crisis
Travel independently to and from the nearest bus stop or up to ¼ mile				
Identify the correct bus stop or transfer point				
Go up and down three 12-inch steps using a handrail if needed.				
Ask for, understand and carry out instructions to take a trip				

6. Specify why the individual's disability prevents use of Shore Transit fixed route service.

Favor de leer y firmar

Por este medio yo certifico que esta información es verdadera y correcta.

_____ Firma

_____ Fecha

_____ Print Name Address