



**MVCS Transportation Access Program (TAP)
Application for Transportation Assistance
Future Medical Expenses**

APPLICANT INFORMATION

Name of Applicant: _____ Date of Application: ___/___/___

Your marital status: Married Single Divorced Separated Widowed

Is this application for yourself? Yes No If no, name of individual: _____

Age of individual in need of transportation assistance: _____ DOB: _____ Gender: _____

Race: Native American Asian White African American Brazilian Portuguese Other

Applicant mailing address: _____ Email: _____

Phone/Cell Phone #: _____ Best time to call: _____

Number of family members who live with you: _____

Employed? Yes No Type: Self Full-time Part-time

Do you have current medical insurance? Yes No If yes, type(s): _____

APPOINTMENT AND TRANSPORTATION INFORMATION

Date and time of appointment: ___/___/___ :___ Location: _____ proof*

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Date and time of appointment: ___/___/___ :___ Location: _____ proof*

Date and time of appointment: ___/___/___ :___ Location: _____ proof*

Date and time of appointment: ___/___/___ :___ Location: _____ proof*

Transportation costs covered by insurance? Yes No Partially

List other agencies contacted for travel assistance: _____

TRANSPORTATION FINANCIAL ASSISTANCE REQUESTED

- SSA Auto Ticket
- SSA passenger Ticket(s)
- GAS Card

ASSISTANCE PROVIDED

<input type="checkbox"/> SSA Passenger(s)	Card# _____, _____, _____, _____, _____	\$ _____
<input type="checkbox"/> SSA Auto (s)	Card# _____, _____, _____, _____, _____	\$ _____
<input type="checkbox"/> GAS	Card# _____, _____, _____, _____, _____	\$ _____
<input type="checkbox"/> BUS	INFO: _____	\$ _____
<input type="checkbox"/> OTHER	INFO: _____	Total \$ _____

I certify that the above information is true and correct to the best of my knowledge. I also certify that the resources requested are being used for travel to/from Martha's Vineyard for medical service(s) appointment(s).

Applicant Signature: _____ Date: _____

Completed by: _____