

**Town of West Hartford Dial-A-Ride  
Medical Access Program (MAP)  
MEMBERSHIP APPLICATION**

July 1, 2014 – June 30, 2015

**You must be a member of West Hartford Dial-A-Ride (separate application)**

**Eligibility:**

MAP membership requires that riders are West Hartford residents having ongoing need for urgent medical transportation, such as kidney dialysis, chemotherapy treatment, or similar need, etc..

**APPLICANT INFO:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt. # \_\_\_\_\_ West Hartford, CT 061 \_\_\_\_\_ (Zip Code)  
Phone: (860) \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

**URGENT MEDICAL NEED:**

**In relation to the information provided in this section, West Hartford Social Services may require additional medical documentation from your physician.**

Transportation to: Name of facility: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
Town: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone number of facility: \_\_\_\_\_

**Time of day transportation needed: (available Mondays, Wednesdays, Fridays from 9:00am – 3:30 pm)**

	Pick-up at Home	Pick-up at Facility
Mondays	from _____	to _____
Wednesdays	from _____	to _____
Fridays	from _____	to _____

**Expected Duration of Transportation Need:**

From \_\_\_\_\_ To \_\_\_\_\_ ~OR~ \_\_\_\_\_ Indefinite  
Date Date (check)

**PLEASE CONTINUE ON OPPOSITE SIDE**

**Personal Info - Special Accommodations:**

Wheelchair Used? Yes \_\_\_\_\_ No \_\_\_\_\_      Hearing Impaired? Yes \_\_\_\_\_ No \_\_\_\_\_

Wheelchair Type: Electric \_\_\_\_\_ Manual \_\_\_\_\_      Visually Impaired? Yes \_\_\_\_\_ No \_\_\_\_\_

Special Assistance Required? Yes \_\_\_\_\_ No \_\_\_\_\_      Cane \_\_\_\_\_ Walker \_\_\_\_\_

Additional Notes: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

**Back-up transportation source in emergency: (Ex: taxi, neighbor, son, etc.)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_

**Emergency Daytime Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_

**Medical Certification:**

I, \_\_\_\_\_, hereby certify that Medical Access Program applicant:  
\_\_\_\_\_, DOES need urgent, ongoing medical services as described  
on page one of this application and will continue to need this service until: \_\_\_\_\_.

Certifier's Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Date Signed: \_\_\_\_\_

\_\_\_\_\_  
**Applicant Signature (or Power of Attorney)**

\_\_\_\_\_  
**Date**

There is no fee for this Medical Access Program (MAP). A separate Dial-A-Ride membership application is required for MAP membership. The annual fee for Dial-A-Ride membership is \$50 a year. If you are not yet a member of Dial-A-Ride, please request an application and mail it with this form along with the membership fee to:

**West Hartford Dial-A-Ride MAP Program  
50 South Main Street, Rm. 306  
West Hartford, CT 06107**

Please feel free to contact the office with any questions ~ (860) 561-7561