TRIPS FOR TOTS

Childhood Immunization Transportation Program

APPLICATION FOR ASSISTANCE

(Please Print All Information)

FACILITY: ______________________________

MOTHER'S NAME: ______________________ **SS#:** ______________
(Last Name, First Name)

ADDRESS: ______________________________ **ZIP CODE:** ____________

______________________________ **PHONE #:** ____________

INCOME (indicate whether monthly or weekly): ________________

BABY'S NAME	SS#	DATE OF BIRTH	BOY/GIRL	RACE

DOES BABY HAVE ANY MEDICAL CONDITIONS OR SPECIAL NEEDS? (Please explain):

____

____

DO YOU REQUIRE ANYONE ELSE TO ATTEND APPOINTMENTS WITH YOU & YOUR BABY? (circle any that apply)

OTHER CHILDREN HUSBAND/BOYFRIEND PARENT OTHER RELATIVE OTHERS

BABY'S CURRENT MEDICAL COVERAGE IS (circle one):

GATEWAY BEST MED PLUS CHIPS OTHER NONE

DID YOU PARTICIPATE IN THE MOBILE MOMS PROGRAM? YES NO

PEDIATRICIAN NAME AND/OR CLINIC ATTENDED: ______________________

ADDRESS: ______________________________ **PHONE #:** ____________

TRAVELERS AID AND THE PARTICIPATING HOSPITALS HAVE NO LIABILITY FOR ANY TRANSPORTATION PROBLEM OR INJURY YOU MAY ENCOUNTER WHILE ENROUTE TO/FROM YOUR APPOINTMENT. IF FOR SOME REASON YOU DO NOT ATTEND AN APPOINTMENT, YOU MUST RESCHEDULE. YOU MAY NOT USE THE VOUCHER FOR ANY PURPOSE OTHER THAN ATTENDING YOUR WELL BABY CHECKUP. ANY UNAUTHORIZED USE OR TRANSFERENCE OF THE VOUCHER WILL RESULT IN THE TERMINATION OF ASSISTANCE.

I UNDERSTAND ALL OF THE RULES AND REGULATIONS OF THE PROGRAM AND AUTHORIZED TRAVELERS AID TO RECEIVE OR REQUEST ANY PERTINENT INFORMATION CONCERNING MYSELF FOR THE WELL BABY CHECKUP TRANSPORTATION I RECEIVE. NO SPECIFIC DIAGNOSTIC MEDICAL INFORMATION WILL BE RELEASED TO TRAVELERS AID. I ALSO AGREE TO PARTICIPATE IN ANY FOLLOW-UP SURVEY THAT MAY BE CONDUCTED BY TRAVELERS AID.

SIGNATURE: ______________________________ **DATE:** ______________