**Referral Form for Community Transportation**

**with Contracted Providers**

(OAR [411-015-0007(9)](https://www.oregon.gov/DHS/SENIORS-DISABILITIES/SPPD/APDRules/411-015.pdf); OAR [411-030-0055](https://www.oregon.gov/DHS/SENIORS-DISABILITIES/SPPD/APDRules/411-030.pdf))

Date of Request: Click here to enter text. Time of Request: Click here to enter text.

Individual transportation contractors may have their own referral forms and process. CMs/LO staff are *not* required to use this form but may do so to provide ride information to a transportation provider.

Consumer’s name: Click here to enter text. Prime #: Click here to enter text.

Address: Click here to enter text. Home/Cell phone #: Click here to enter text.

Consumer’s living situation: [ ]  Private home

[ ]  Apartment-Floor (1st, 2nd, etc.): Click here to enter text.

Contact information if other than consumer (i.e., Rep.): Click here to enter text.

Are other Community Transportation services or supports available (i.e., natural supports, public transit, volunteer transportation, etc.)? [ ]  Yes [ ]  No

Contracted transportation providers name: Click here to enter text.

**\***Transportation needed (Check all that apply):

[ ]  Grocery shopping (Eating/Meal prep.) [ ]  Gym/swimming pool (Mobility)

[ ]  Clothes shopping (Dressing) [ ]  Adult Day Meal site (Eating)

[ ]  Beauty/barbershop (Grooming) [ ]  Restaurant (regularly scheduled site)

[ ]  Medicine (Medication Management) [ ]  Worksite (OSIPM-EPD only)

**\***Rides are prior authorized for individuals to gain access to resources and services in their community linked to their ADL/IADL needs. Rides are not authorized for medical appointments or to destinations not related to an individual’s care needs (i.e., community/family events, recreational sites, volunteer work, etc.).

Wheelchair lift required? [ ]  Yes [ ]  No Oversized wheelchair? [ ]  Yes [ ]  No

Mobility device required? (Check all that apply):

[ ]  Cane [ ]  Crutches [ ]  Walker [ ]  Wheelchair/transport chair [ ]  Scooter

Volunteer attendant required? [ ]  Yes [ ] No – If yes, name: Click here to enter text.

Identified issues that may affect the successful delivery of transportation services:

Click here to enter text.

**Case Manager Authorization**

Number of one-way rides to approved destinations prior-authorized per month: Click here to enter text.

Date range for approved services: (MM/DD/YYYY): Click here to enter text. - Click here to enter text.

Termination date (per services plan): Click here to enter text.

CM name: Click here to enter text. CM signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CM email: Click here to enter text. CM phone #: Click here to enter text.

Notes: Click here to enter text.

**TRANSPORTATION OFFICE USE ONLY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Quarter** | **Date Issued** | **# of Rides Issued** | **Authorized Signature** | **Billing Issued** | **Payment Received** |
| Jan.-Mar. |  |  |  |  |  |
| Apr.-June |  |  |  |  |  |
| July-Sept. |  |  |  |  |  |
| Oct.-Dec. |  |  |  |  |  |