Mid Shore Behavioral Health, Inc.
Consumer Support Services
Consumer Transportation Request Form

DATE: _____

Please complete all sections. INCOMPLETE FORMS WILL BE DENIED AND RETURNED
Please print legibly.

Consumer Name:_____ DOB: _____

Address:_____ County: _____

Telephone #:_____ Social Security #:_____

Veteran: Yes No Gender: _____ Primary Language:_____

Ethnicity: African American Caucasian Hispanic Asian Native American Other Unknown

Is client a consumer of Public Behavioral Health Services? Yes No
Is client receiving treatment for a substance use disorder? Yes No
Is consumer presently receiving mental health services? Yes No

Pick-up Location: _____ **Drop-off Location:** _____

_____ _____

_____ _____

_____ _____

Roundtrip **Yes** **No**

Please provide a detailed description of the transportation assistance needed.

_____

_____

_____

_____

Please list <u>all</u> agencies such as DSS and other charitable organizations that have been contacted and note reason for refusal: Must have contacted a minimum of 3 agencies.

Agency Name:_____

Contact Person:_____

Telephone #:_____

Result:_____

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Agency Name:_____

Contact Person:_____

Telephone #:_____

Result:_____

Agency Name:_____

Contact Person:_____

Telephone #:_____

Result:_____

If additional agencies contacted list the name, number contact person and result.

Total dollar amount requested: _____

Funding is needed by:_____

Check should be made payable to:

Name:_____

Address:_____

Telephone #:_____

Tax I.D. #:_____

Consumer Signature:_____ **Behavioral Health Provider Signature**:_____

Telephone/Email _____ Telephone/Email _____

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Consumer Name:_____

CSA USE ONLY

Approved Amount: _____ Denied: _____ Withdrawn: _____ Date:_____

Special Need Funds: _____

Comment: _____

Signature of staff processing request: _____

Executive Director, Deputy Director, or Board President Signature: _____

BHA Approval (if request is over $1000.00): _____

CSA Special Needs Request Notes: