Ryan White Part A Request for Client Assistance Funds
Fiscal Year 2017 - 2018

TRANSPORTATION

Client URN: _____

Case Manager: _____ **Email:** _____

Agency: _____

Address: _____

Phone: _____ **Fax:** _____

Reason for Request (Please be specific):

List the other funding sources you have attempted to access to get this request paid. If you received a payment, please indicate the amount(s). That amount will be deducted from the request.

Has the client applied for any of the following assistance programs? If so, please indicate date of application and outcomes.

☐ **Logisticare** _____ ☐ **First Transit** _____

☐ **Basic Needs Program** _____

Amount of Request: _____

Send bus pass / tokens to:

Case Manager Signature: _____ **Date:** _____

Case Manager Supervisor Signature: _____ **Date:** _____

FOR OFFICE USE ONLY	**Funds Used:** ☐ **RWA** ☐ **RWB**

AIDS Connecticut

Transportation Arrangement Form

(Request for Bus Pass/Tokens)

Please fill out form in its entirety and return it via fax to 860-761-6711.

Client ID:			Date:	
Client Name:			Age:	
Address:			Apt:	
City:			State: CT	Zip:
Agency:			MCM Email:	
Case Manager:			Phone:	
Race:	Ethnic:	Gender:	HIV Status:	Transmission:

For each of the following service types, please provide the total number of appointments for the month.

Service Type	Place	# of Appointments	Date
Methadone Program			
Medical Appointment			
Mental Health			
Substance Abuse Counseling			
Lab Tests			
Support Group			
Other			

For ACT Transportation Program Use Only

Number of Bus Pass/Tokens for Client: _____ Last URS/CareWare Update: _____

Case Manager Contact Log:

Date: _____ Issue: _____

Date: _____ Issue: _____

Date: _____ Issue: _____

Date: _____ Issue: _____