STATE OF HAWAII
Department of Human Services

Med-QUEST Division

Please mail to:
Unit _____
Address: _____
Worker: _____

REQUEST FOR INDIVIDUALIZED TRANSPORTATION SERVICES

Last Name	First Name	M.I.	Case Name	Case No.	Date of Birth	Sex (M/F)

Street Address	City/State	Zip Code	Telephone No.

I. CLIENT: THIS SECTION MUST BE THOROUGHLY COMPLETED OR IT WILL BE RETURNED TO YOU

A. Are you able to use public transportation **or** can someone regularly transport you to obtain medical services? _____
(If you answer yes, you will not be eligible for individualized transportation services.) (**Yes** / **No**)

B. Explain why you should receive individualized transportation: _____

C. List the names of your medical providers, frequency and the locations for which your need individualized transportation:

D. I certify that the above information is true and accurate to the best of my knowledge.

Signature of Recipient or Legal Guardian	Printed Name of Recipient or Legal Guardian	Date

II. LICENSED PHYSICIAN: COMPLETE INDIVIDUALIZED TRANSPORTATION NEED ASSESSMENT

A. Diagnoses:

1) _____ 2) _____ 3) _____

B. Provide an explanation of all physical and/or mental impairments: _____

C. Provide an explanation whether your patient's impairment(s) will be temporary or permanent: _____

D. List all assertive devices (i.e., **wheelchair, walker, cane, etc**.): _____

III. LICENSED PHYSICIAN: COMPLETE CERTIFICATION OF INDIVIDUALIZED TRANSPORTATION REQUEST

A. I certify that it is medically necessary for _____, to be granted access to:
Recipient's Name

taxi ____ **curb-to-curb(van/Handi-van)** ____ **door-through-door(handi-cab)** ____ services from _____ (Month/Year) to _____ (Month/Year)

Signature of Licensed Physician	Printed Name of Physician	Address	Phone No.

AFTER COMPLETING SECTIONS II AND III, PLEASE MAIL FORM TO THE ADDRESS LISTED ON THE UPPER RIGHT CORNER

IV. WORKER: AUTHORIZATION IS TO BE COMPLETED AT EACH ELIGIBILITY REVIEW FOR A PERIOD NOT TO EXCEED ONE (1) YEAR

APPROVAL _____ (**is**) (**is not**) GRANTED FOR _____ (**taxi** / **curb-to-curb** / **door-through-door**) FROM _____ (Month/Year) TO _____ (Month/Year)

Signature of Eligibility Worker	Printed Name of Eligibility Worker	Date

DHS 1160 (Rev. 05/97)