A Nonprofit Charity - Est.1979

Easy Lift Transportation

Non-Emergency Accessible Transportation Service Request

Reservations Ph: (805)681-1181 Opt.2 Fax: (805) 681-1184
Program Coordinator: (805) 692-6923

Section 1: Member Information

Name: _____ Date of Birth: _____ □ M □ F

Cencal Member ID or SSN:_____

Address: _____ Unit #: _____

City: _____ State: _____ Zip: _____ Complex:_____

If this is a "Gated Community", please provide gate code: _____

Day Phone #: _____ Evening #: _____ Cell # _____

Email: _____ Preferred Language: _____

Mailing address if different: _____

*Please provide the name of a **Local** friend or relative to call in case of emergency*

Name: _____ Relationship: _____

Day Phone #: _____ Evening #: _____ Cell #: _____

Email: _____

Section 2: Patient's Mobility Type/ Medical Visit Type

Which one of the following mobility aids, if any, do you use?

□ Crutches □ Power Wheelchair □ Service/Guide Animal
□ Cane □ Power Scooter □ Portable Oxygen
□ Walker □ Manual Wheelchair □ Other _____ □ None

What type of doctor appointments will you most frequently visit?

□ Dialysis □ Cancer Center □ Primary Care
□ Therapy □ Chiropractor □ Counseling
□ Acupuncture □ Other _____

Section 3: Cencal Provider Referral *Must be completed by medical professional*

In order to maintain an active status with NEAT, a medical transportation referral must be updated every **six months** by a Cencal Health provider. The following will serve as the initial referral. It is suggested that the medical referral come from the doctor whom the patient will most frequently visit.

Name of Prescribing Physician: _____
Medical Specialty: _____
Provider's Agency: _____
Address: _____
City: _____State: _____ Zip Code: _____
Telephone #: _____
Fax #: _____
Email: _____
Best Form of Contact: _____

Please Initial:

____ I hereby acknowledge that the aforementioned patient requires transportation to medical appointments.

Subsequent referrals must be completed by filling out the Renewal Request Form. You can obtain a copy online or by calling the Program Coordinator at (805) 692-6923.

CERTIFICATION OF APPLICANT

- I hereby acknowledge that, to the best of my knowledge, information given in this application is correct.

Signature: _____ Date: _____

If someone other than the applicant completed this application, their information must be provided.

Name of person completing or assisting with the application (*please print*)

_____

Relationship to Applicant: _____

Signature of Assistant: _____**Date**: _____

Daytime Phone: (_____) _____-_____ Evening Phone: (_____) _____-_____