

PLEASE PRINT, COMPLETE AND MAIL OR FAX TO:

ECTC INC.

18 Meridian Street

New London, CT 06320

Phone: 860-439-1207

Fax: 860-439-1209

EASTERN CT TRAVEL VOUCHER APPLICATION

ELIGIBILITY REQUIREMENTS

- Applicant - must have a physical or mental impairment that substantially limits one or more major life activities.

SECTION 1 - PLEASE PRINT CLEARLY

Applicant's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

Optional Demographic Information:

Date of Birth (optional): _____ Gender: M F (Circle one)

Ethnicity: Black White Asian Hispanic Other (Circle One)

Applicant's Signature: _____ Date: _____

In an effort to gather information to research and create new or enhance current transportation options please provide feedback on the following questions:

Please identify any transportation barriers that are currently affecting you?

**What services would you like to see implemented that could eliminate these barriers?
Please Describe (i.e. weekend service in Danielson, etc))**

SECTION 2

Must be completed by a healthcare professional.

Patient's Name: _____

Is the disability temporary or permanent? _____

Length of disability, if temporary: _____

Briefly, state nature of disability: _____

Name of healthcare professional completing form: _____

Address: _____ City: _____

State: _____ Zip: _____ Telephone: _____

Healthcare Professional's Signature: _____ Date: _____

SECTION 3 (Completed by ECTC)

Date Rec'd: _____

Client ID#: _____