



# Door-to-Door Trip Request Form

You may fax or submit online via the portal at: [www.hopelink.org/programs/medicaid-transportation/](http://www.hopelink.org/programs/medicaid-transportation/)

Hopelink Mailing Address: 14812 Main St., Bellevue, WA 98007

Phone (King County): (800) 923-7433 | Phone (Snohomish County): (855) 766-7433 | Fax: (425) 644-9447

**FAX MUST BE RECEIVED BEFORE 5:00PM TWO (2) BUSINESS DAYS IN ADVANCE**

## CLIENT INFORMATION

Client Name:		Client Provider One Number:	(May substitute with D.O.B.)
Contact/ Requestor Name:		Phone Number:	

## ASSISTANCE NEEDS

**Is the client able to travel to and from their appointment independently?\*** Yes:  No:

\*If you answered "No" to the above question the client or caregiver must arrange to have an attendant provided

**Total Number of Riders:** \_\_\_\_\_ (More than 3 riders may limit the transportation resources available and result in service delays)

**Does the client use a wheelchair/scooter?\*** Yes:  No:  If yes, what size?\* Standard:  XL:

\*Standard sized wheelchair is 48" x 30" measured wheel to wheel

**Other client mobility needs:** \_\_\_\_\_

(Ex: Can transfer unassisted from wheelchair into sedan / visually impaired / car seat / booster seat / etc.)

## APPOINTMENT INFORMATION

Medical Reason (please provide a brief description): _____			
Starting Address:			
Facility Address:			
Facility Name:	Entrance: (if applicable)		
Is the service billable to Medicaid (Title 19)? Yes: <input type="checkbox"/> No: <input type="checkbox"/>		Facility Phone #:	
Appt. Date: (mm/dd)		Appt. Time:	Return Time:
Confirmation Phone #:	Confirmation Fax #:		

## CONFIRMATION INFORMATION *(To be completed by Hopelink Staff)*

Was the request completed?: Yes:  No:  Hopelink staff initials: \_\_\_\_\_ Date: \_\_\_\_\_

Comments: \_\_\_\_\_

Scheduled pickup time: \_\_\_\_\_ Scheduled return time: \_\_\_\_\_