Transportation Request Form-NBRC

Office: 1-800-966-7114 Ext. 203
Fax: 1-866-529-6102
E-Mail: TRF-NBRC@rdtsi.com

Request Type: Date Generated: _____ Start Date: _____ Term Date: _____ ☐ Until Cancelled

☐ New Service ☐ Change ☐ Cost Analysis ☐ Cancellation ☐ Travel Training ☐ Other: _____

If Change, please mark type: ☐ Address ☐ Program ☐ Days ☐ Service (modify trip) ☐ Vendor Supervisor Signature: _____

Service Coordinator: _____ Phone: _____ SC E-mail: _____

Client Information: Client Name: _____ UCI #: _____ DOB: _____ ■ Female ☐ Male

Emergency Contact Name: _____ Phone Number: _____ Relationship: _____

Conserved: ■ Yes ☐ No If Yes, Conservator Name: _____ Phone Number: _____

Client AM pickup Address: _____ Primary Contact Name: _____ Primary Phone Number: _____

Client PM drop off Address: Primary Contact Name: _____ Primary Phone Number: _____

Residential Placement (mark all that apply): ☐ Family ☐ Independently ☐ ILS ☐ RSP ☐ CCF ☐ ICF ☐ SLS ☐ FHA ☐ Other: _____

May Be Released Unsupervised: ☐ Yes ☐ No **If Yes, please attach Release to Self Authorization Form along with the Transportation Request Form**

Destination Information: Program Name: _____ Contact Name: _____ Phone Number: _____

Program Address (incl. city & zip code): _____ Program Vendor #: _____

Supportive Employment: ☐ 950 Group ☐ 952 Individual ☐ 954 WAP ☐ Other: _____

Program Service Code: ☐ 510 ADC ☐ 515 BMP ☐ 055 Medical ☐ 055 Behavioral ☐ Other: _____

Days of Attendance: ☐ Mon - Fri ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri Program Hours: Start Time: _____ End Time:

Type of Service: ■ AM & PM (round trip) ■ AM ONLY (to program) ■ PM ONLY (return home)

Development Disability Diagnosis: _____ Allergies: _____ No Known allergies: ☐

Please mark all that apply and include any additional information in the Notes section to assist with transportation safety:

MOBILITY		BEHAVIOR	VISION	SPEECH
☐ Ambulatory	Individual requires use of:	☐ SC has confirmed no behaviors are present	☐ No vision concerns	☐ English
☐ Poor balance	☐ Manual wheelchair	☐ Verbal aggression	☐ Impaired	☐ Other Language: _____
☐ Fall risk	☐ Electric wheelchair	☐ Physical aggression	☐ Legally Blind	☐ Non-verbal
☐ Unsteady gait	☐ Over-sized wheelchair	☐ Wandering	HEARING	☐ ASL
☐ Support cane	☐ Electric scooter	☐ Disruptive	☐ No hearing concerns	☐ Intelligible to unfamiliar listener
☐ Crutches	☐ Walker	☐ Self-injurious	☐ Impaired	☐ Intelligible to familiar listener
☐ Requires two seats	☐ Other: _____	☐ Other: _____	☐ Deaf	☐ Augmentative Communication

History of Seizures: ☐ Yes ☐ No
If Yes, please provide the following important information.
Regulated with medication: ☐ Yes ☐ No Date of last seizure: _____

Attendant: ☐
Please note that if an attendant is required during transportation, a cost analysis must be reviewed and approved by NBRC before implemented.

NOTES:

THIS SECTION FOR R&D SCHEDULING DEPARTMENT USE ONLY

DATE RECVD _____ SCHLD BY _____ EFFECTIVE DATE _____ PRGM NOTIFICATION: _____

	ROUTE	TIME	VENDOR ID	VENDOR #
AM				
PM				

PERSON SERVED NOTIFICATION: _____

NOTES: _____

Please consider the environment when printing this form and print double sided

*THIS SECTION IS FOR NBRC CASE MANAGEMENT USE ONLY

IN ACCORDANCE WITH TITLE 17 ALL GENERIC RESOURCES MUST BE RULED OUT PRIOR TO ASSIGNING TO ROUTED SERVICE.

ARE THE FOLLOWING GENERIC OPTIONS AVAILABLE TO THE PARTICIPANT AND DO THEY ACCOMMODATE THEIR NEEDS TO AND FROM PROGRAM? (PLEASE MARK ALL THAT APPLY)

HOME/PARENTS/FAMILY TRANSPORT: ☐ Yes ☐ No ☐ N/A IF NO, PLEASE PROVIDE REASON: _____

SUPPORTIVE LIVING SERVICES (SLS) PROVIDER: ☐ Yes ☐ No ☐ N/A IF NO, PLEASE PROVIDE REASON: _____

RESIDENTIAL SERVICE PROVIDER (RSP/FHA/ICF/CCF): ☐ Yes ☐ No ☐ N/A IF NO, PLEASE PROVIDE REASON: _____

CARE FACILITY: ☐ Yes ☐ No ☐ N/A IF NO, PLEASE PROVIDE REASON: _____

IS THE PARTICIPANT A CANDIDATE FOR TRAVEL TRAINING IN ODER TO UTILIZE FIXED ROUTE SERVICE?: ☐ Yes ☐ No ☐ N/A IF NO, PLEASE PROVIDE REASON: _____

IS THE PARTICIPANT ELIGIBLE FOR PARATRANSIT SERVICES?: ☐ Yes ☐ No ☐ N/A IF NO, PLEASE PROVIDE RESON: _____

DOES THE PARTICIPANT HAVE THE ABILITY TO:

RIDE A BICYCLE: ☐ Yes ☐ No

DRIVE THEIR OWN CAR: ☐ Yes ☐ No

WALK TO AND FROM DESTINATION: ☐ Yes ☐ No

RIDE SHARE: ☐ Yes ☐ No CARPOOL: ☐ Yes ☐ No

*COST ANALYSIS EXCEPTION PROCESS

IF THE PARTICIPANT FALLS UNDER ANY OF THE FOLLOWING CATAGORIES, AN EXCEPTION MUST BE GRANTED VIA A COST ANALYSIS with approval from an Associate Director before service can be implemented (PLEASE MARK ALL THAT APPLY).

RESIDES IN A PRIVATE HOME/RSP/CARE FACILITY THAT IS OVER FIFTEEN (15) MILES FROM PROGRAM: ☐

REQUIRES A ONE-TO-ONE ATTENDANT: ☐

EXCEEDS THE AVERAGE COST PER CONSUMER ☐

REASON REQUESTING EXCEPTION: _____

***Please note that NBRC required all the sections be completed before sending to R&D Transportation. Any incomplete forms will be sent back to case management for completion.**

R&D TRANSPORTATION SERVICES

4036 ADOLFO RD. ~ CAMARILLO, CA 93012
(805) 529-7511 ~ FAX (866) 529-6102
Email: custserv@rdtsi.com

Person Served:	**UCI #:**	**Program:**	**Reg Ctr:**
Scheduled Drop Off Address:		**Vendor / Route #:**	

RELEASE TO SELF AUTHORIZATION

I, _____, as parent/legal guardian of
(Print Name)

_____, authorize
(Print Participant's Name)

Check Below:

☐ Delivery of this participant without the presence of adult supervision.

I understand that by signing this authorization R&D Transportation Services, Inc., the transportation provider, the driver, and the Regional Center are released of any liability once the participant is delivered as instructed.

_____ _____
SIGNATURE DATE

_____ (_____) _____
RELATION TO PARTICIPANT PRIMARY PHONE NUMBER

Please note:

- **Upon R&D's receipt of this form, a phone call will be made to the home to confirm your authorization before the driver is notified to release the participant unattended.**
- **The participant must have access to enter the residence and be able to enter the residence on their own.**
- **No statements, other than the required information that is asked, can be written on the Release Authorization Form. Otherwise, the form cannot be processed and this Release Authorization form will not be valid.**

THIS SECTION FOR R&D USE ONLY

CUSTOMER SERVICE	**SCHEDULING DEPT.**
"Rls2Slf" box on Intake is marked ☐ Yes ☐ No	
DATE SENT: _____ CSR INITIALS _____	DATE RECVD: _____
DATE RECVD: _____ CSR INITIALS_____	SCHLD BY: _____
CONFIRMED WITH: _____	EFFECTIVE DATE: _____
COMMENTS: _____	