THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR
COLUMBUS PUBLIC HEALTH

Ryan White Part A
Transportation Assistance Form

Date: _____/_____/_____

Client Information

Client Name: _____ **Date of Birth:** _____/_____/_____

Transportation Assistance

- Bus passes are distributed in an increment of a one-day bus pass (COTA Mainstream bus passes are available on a case-by-case basis, approved by Columbus Public Health).
- Gas cards are distributed in an increment of $5 and are based on the round-trip distance to each documented appointment. Mileage should be calculated per appointment.
  - Less than 10 miles = no gas card
  - 10 – 24.99 miles = $5 gas card
  - 25 miles - 49.99 miles = $10 gas cards
  - For every 25 miles after 50 = $5 gas card

Payer of Last Resort

Ryan White Part A will be considered the payer of last resort if the following cannot be met:

- Client receives bus pass/gas card from another service provider to attend scheduled appointment; or
- Client is reimbursed within two business days following scheduled appointment.

1. Is the client eligible for transportation assistance or reimbursement through another provider? ☐ Yes ☐ No

If YES: **1a. Was effort made to exhaust these resources?**
☐ Yes ☐ No, *resources must be exhausted before providing transportation assistance through Ryan White.*

Appointment Information

2. Appointment Date: _____/_____/_____

3. Appointment Type:

☐ Access to Benefits
☐ Dental
☐ Food Bank
☐ Housing
☐ Linkage to Care Visit
☐ Medical Case Management Visit
☐ Mental Health/Substance Use
☐ Non-Medical Case Management – Support Visit
☐ Outpatient Ambulatory
☐ Ryan White Programming

4. Provider Name/Location: _____

5. Type of Transportation Assistance: ☐ Gas Card ☐ Bus Pass, #_____

5a. *Clients Receiving Gas Cards:*

5a1. Originating Address: _____

5a2. Destination Address: _____

5a3. Round-Trip Mileage: _____ **5a4. Total Number of Gas Cards Distributed:** _____

5a5. Gas Card(s), #_____, #_____, #_____

Client Agreement

6. Will the bus pass(es)/gas card(s) be mailed to the client? ☐ No ☐ Yes, *not necessary to obtain the client's signature below*

I understand that transportation assistance is provided for me to access my medical appointments and/or support services and that I will not be provided with cash payments. I am aware that my provider may be contacted to verify that I attended my appointment(s).

_____ _____
Client Signature *Date*

_____ _____
Professional's Signature *Date*