PLEASE PRINT, COMPLETE AND MAIL OR FAX TO:
ECTC INC.
113 Salem Tpke – Suite 200
Norwich, CT 06360
Phone: 860-859-5791
Fax: 860-859-5796

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))

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____

____

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#: __________________________