Ontario Works Program
Housing and Social Services Department

Medical Transportation Assistance Request

Part 1: To be Completed by Ontario Works Member

Name: Member ID:

Date of Birth (m/d/yyyy): Case Manager Name:

Authorization to Release Information:

I hereby authorize (Name of Health Care Professional)

to disclose the medical and related information requested on page 2 of this Medical Transportation Assistance Request form.

Signature:_____ Date: _____

Notice with Respect to the Collection of Personal Information

(Freedom of Information and Protection of Privacy Act)
(Municipal Freedom of Information and Protection of Privacy Act)

This information is collected under the legal authority of the *Ontario Works Act,* 1997, section 7, 8, 57 & 58 of the *Ontario Disability Support Program Act,* 1997, sections 5, 10, 45 & 46 for the purposes of administering Government of Ontario social assistance programs.

Please complete form in full, sign and take to your Health Care Provider:

Inquiries about this form can be directed to:

Ontario Works, 362 Montreal Street, Kingston, ON K7K 3H5

Phone: 613-546-2695

NOTE: Only Original Documents will be Accepted

Part 2 – To be completed by the Health Care Professional:

Patient's Name: is requesting assistance with medical travel and transportation.

Please briefly detail the patient's medical condition**:** (details below)

Please specify the nature of the necessary appointments**:**

Please state the frequency: visits per week, OR visits per month.

Patient is required to attend these appointments for the next week or weeks, month or months.

NOTE: Bus transportation is the method of transportation covered under this benefit; unless the medical condition renders this type of transportation impossible or impractical

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Please indicate if patient's condition causes him or her to be incapable of using bus transportation to attend these appointments:

☐ Yes, incapable of using bus (Please stamp and initial)

☐ No, capable of using bus (Please stamp and initial)

If yes, please provide details regarding the medical condition that makes them incapable of using bus transportation: .

Also indicate which of the following transportation methods that the patient can use.

(please check all that apply):

☐ Access Bus ☐ Taxi ☐ Train ☐ Own Vehicle

Additional Comments:

Health Care Provider's Name:

Registration Number: Phone Number:

Health Care Provider's Office Address:

Signature:_____ Date:_____