

**Transportation Services**

**T-Transportation 2**

|  |  |  |
| --- | --- | --- |
| AV#: | (7 digits) | Click to enter |
| ACCES-VR ID#: | (6 digits) | Click to enter |
| CAMS ID #: | (10 digits) | Click to enter |

|  |  |  |  |
| --- | --- | --- | --- |
| VR District Office:  | Click to enter | Provider: | Click to enter |
| VRC Name: | Click to enter | NYS Fiscal System ID: | Click to enter |
|  | Report Date: | Click to enter |

|  |  |  |  |
| --- | --- | --- | --- |
| Participant First Name: | Click to enter | Participant Last Name: | Click to enter |
| Participant Phone Number: | Click to enter |
| Participant Email Address: | Click to enter |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| **Number of round trips authorized:**  |  | Click to enter |  |  |
|  |  |  |  |  |  |  |  |  |  |
| **Number of round trips provided this month:** | Click to enter |  |  |
|  |  |  |  |  |  |  |  |  |  |
| **Number of round trips utilized to date:** |  | Click to enter |  |  |
|  |  |  |  |  |  |  |  |  |  |
| **Indicate what core ACCES-VR service (Assessment, Training, Placement) this transportation is supporting:** |
| Click to enter |
|  |  |  |  |  |  |  |  |  |  |
| **What is the expected duration of this service:** | Click to enter |  |  |
|  |  |  |  |  |  |  |  |  |  |
| **What is the estimated date this service will conclude:** | Click to enter |  |
|  |  |  |  |  |  |  |  |  |  |
| **Type of vehicle utilized for this service:** |  | Click to enter |  |  |
|  |  |  |  |  |  |  |  |  |  |
| **List appropriate DMV licensure for staff providing service:** | Click to enter |
|  |  |  |  |  |  |  |  |  |  |
| **Is current and valid DMV licensure, Defensive Driving certificate, and background documentation maintained in vendor records subject to monitoring review at ACCES-VR request:**  |
| Click to enter |
|  |  |  |  |  |  |  |  |  |  |
| ***Any tickets or accidents incurred while driving participant must be reported immediately to VRC. Were any tickets or accidents incurred while driving the participant?*** |
|  |[ ]  Yes |[ ]  No |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| ***If yes, please describe:***  |  |  |  |  |  |  |
| Click to enter |
|  |

|  |
| --- |
| **Completed By:**  |
|  |  | Click to enter |
| Licensed Staff Signature |  | Date |  |
| Click to enter |  | Click to enter |
| Printed Name |  |  | Title |  |
| Phone Number: | Click to enter |  | Email: | Click to enter |