

**Transportation Services**

**V-Transportation I**

|  |  |  |
| --- | --- | --- |
| 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 | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | | |
| **What transportation is being purchased for the participant?** (ie. Public transit passes, para transit passes, taxi service, ride sourcing service) | | | | | | | | | |
| Click to enter | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |
| **Number of units authorized in total:** | | | | | Click to enter | |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| **Number of units 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 | | |
|  |  |  |  |  |  |  |  |  |  |
| **Has the participant signed off on the actual costs?** | | | | | |  | **Yes** |  | **No** |
|  |  |  |  |  |  |  |  |  |  |
| **Are the actual costs for this participant documented in facility records?** | | | | | | | | |  |
|  |  |  |  |  |  |  | **Yes** |  | **No** |
|  |  |  |  |  |  |  |  |  |  |
| *The documentation of actual costs may be requested in a quality monitoring review.* | | | | | | | | |  |
|  |  |  |  |  |  |  |  |  |  |

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