Per Trip Non-Medical Transportation – SERVICE DELIVERY DOCUMENTATION FORM – County _____

PROVIDER NAME: _____ **PROVIDER #:** _____

Date	Vehicle License Plate Number	Start time of trip	End time of Trip	All passengers, staff, and/or volunteers in the vehicle during any portion of the commute *Used in conjunction with Key below*									Driver Initials
				1	2	3	4	5	6	7	8	9	

Per Trip Non-Medical Transportation – SERVICE DELIVERY DOCUMENTATION FORM – County _____

PROVIDER NAME: _____ **PROVIDER #:** _____

Key	Individual/Staff/Volunteer Name	Individual Medicaid Number (if applicable)
1		
2		
3		
4		
5		
6		
7		
8		
9		

If vehicle is modified or equipped to transport five or more passengers, annual and daily inspections are required and maintained on additional documentation sheets.

Printed Name:_____ Signature: _____ INITIALS: _____ DATE: _____

Printed Name:_____ Signature: _____ INITIALS: _____ DATE: _____

Printed Name:_____ Signature: _____ INITIALS: _____ DATE: _____

Printed Name:_____ Signature: _____ INITIALS: _____ DATE: _____

Printed Name:_____ Signature: _____ INITIALS: _____ DATE: _____