Chesapeake Bay Bridge Tunnel Ticket Application

Date: ___________________

Patient Name: ____________________ Phone #: ________________________

Address: ____

Social Security Number: ______________________________

1. How did you hear about this program? Please circle one:
   Friend/Relative   Doctor   Advertisement
   Chesapeake Bay Bridge Tunnel
   Other (please explain) ____

2. What is the crisis and/or chronic medical condition which requires CBBT travel? Please circle one:

Cancer	Cardiology	Dental	Dermatology
Diabetes	Dialysis	Gastro	Neurology
Orthopedics	Pain Mgmt.	Prenatal	Surgery

   Family member in hospital
   Other (please explain) ____

3. Where do you go to the doctor for routine visits? Please circle one:
   ESRHS – Eastern Shore Rural Health
   Perdue Wellness Center   Riverside Physicians
   Other: ____

4. Are you currently on ESRHS' sliding fee scale? _____ Yes _____ No
   (If "Yes" – patient does not need to provide proof of income – verify in EClinical.)

5. Do you have Medicaid or a Medicaid HMO? ____ Yes ____ No
   (If "yes" – patient should receive tickets from Health Department.)

6. Are you a veteran? ____ Yes ____ No

List every member of your household including yourself:

Name	Date of Birth	Relationship	Source of Income	Amount before taxes

I give the following individual(s) permission to pick up passes for me:

____________________ ____________________ ____________________

I certify that the information given is true and complete to the best of my knowledge and belief. I understand that my Primary Care Provider's Office and/or Eastern Shore Rural Health System, Inc. may verify my income in order to determine my eligibility for Chesapeake Bay Bridge Tunnel Tickets.

________________________ ____

Date Applicant's Signature

This information needs to be updated on a yearly basis.

Internal use only:

Notes: ____

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