TAP ID # _____

Island Health Care Travel Assistance Program Application

How Does the TAP Work?

All Island Health Care patients are eligible to apply for travel assistance to medical and/or mental health appointments. Requests will be reviewed on a case-by-case basis. This program operates as needed, meaning that patients are required to explore other sources of transportation assistance before applying. Please note that you are required to document your findings and failure to report will result in an incomplete application and delayed processing times. If you would like to learn more about transportation resources, please reach out to our Community Health Workers who can guide you to appropriate resources.

Expenses that qualify under this program include, but are not limited to: ferry tickets, bus transportation, taxi rides, and hotel accommodations. This is not an all-inclusive list – please note any unique needs on the application (e.g. payment for a car service, parking, tolls etc.). Retroactive applications can be submitted for reimbursement for expenses dating back to February 1 of the current year. When requesting reimbursement, receipts for covered expenses are required. If you are unable to attach a receipt, a credit or debit card statement is acceptable. You can expect to receive your reimbursement within three weeks of application approval.

Application Process

Applications can be submitted three ways: (1) email, (2) mail, or (3) hand delivery.

- (1) Email: Fill out online (or by hand and scan in) and email to hdolan@ihimv.org with the subject line "IHC-TAP"
- (2) Mail to: IHC-TAP, PO Box 9000, Edgartown, MA 02539
- (3) Hand deliver to: IHC at 245 Edgartown Vineyard Haven Road at the triangle in Edgartown

Applications will be processed on a first-come first-served basis. Applicants will be notified by phone or email regarding the status of their application.

Please attach copies of all receipt(s) and/or credit or debit card statement(s). **If you need help filling out this form or have any questions, please call our Community Health Worker FIRSTNAME LASTNAME at XXX-XXX-XXXX.**

Applicant's Name (first, last):	Date of Application: ____/ ____/ _____
Mailing Address:	Date of Birth (MM/DD/YYYY):
Email:	Primary Phone Number (best number to reach you at):

FOR OFFICIAL USE ONLY: CHW-assisted application? ☐YES ☐NO If YES, please initial here:

Are you covered by health insurance? ☐YES ☐NO

If yes, please provide the following information:

Insurer(s):_____, _____

TAP ID # _____

Appointment & Transportation Information

Are you requesting **reimbursement** for travel that has already happened? ☐YES ☐NO

Does your insurance cover transportation costs? ☐YES ☐NO ☐PARTIALLY
If yes or partially, please explain: _____

Do you need overnight accommodation (e.g. early morning appointment)? ☐YES ☐NO

Name of Specialist / Doctor / Provider	**Department**	**Location and Phone Number**	**Date and Time of Appointment**	**Verification** *To be completed by IHC staff*
VERIFICATION STATUS (include staff signature):				

Transportation financial assistance requested (please check all that apply):

☐SSA PASSENGER ☐SSA AUTO ☐BUS ☐GAS ☐HOTEL ☐TAXI ☐OTHER

If other, please specify and include the price if it is known: _____

If requesting a gas voucher, how much does it cost to fill your car's tank? _____

I certify that the above information is true and correct to the best of my knowledge. I also certify that the resources requested are being used for travel to and/or from Martha's Vineyard for medical appointment(s).

_____ _____ _____
Full Name (Print) Signature Today's Date

FOR OFFICIAL USE ONLY:
Patient Name:
Approved Travel:
Approved By:
Date Approved:
List the documents used for future travel or reimbursement. Please attach a copy of each.