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
   Riverside Physicians (ESPS) OBGYN Associates
   Cape Charles Medical Metompkin Medical
   Eastville Medical Perdue Wellness Ctr
   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 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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