

Chesapeake Bay Bridge Tunnel Ticket Application

Date: _____

Patient Name: _____ Phone #: _____

Address: _____

Social Security Number: _____

1. How did you hear about this program? Please check 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 Check One:

- Cancer Dialysis Prenatal Care/Premie
 Cardiology Neurology
 Dental Orthopedics
 Surgery (not including cardiology, cancer, orthopedics, neurology)
 Other (please explain) _____

3. Where do you go to the doctor for routine visits? Please check one:

- ESRHS - Eastern Shore Rural Health
 ESPS – Eastern Shore Physicians & Surgeons
 Clarke/Dalessio Snyder/Gibb/Rupp
 Lingle/Goldstein Amrien
 Wolffe Gubb/Rayfield
 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 Megawest)

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

List every member of your household including yourself:

Name	Birthdate	Relationship	Source of Income	Amount before taxes
SELF		SELF		

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

<p>Internal Use Only:</p> <p>Notes: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
