



Client's Name: _____

Legal Guardian's Name (if applicable): _____

Client's Date of Birth: _____

I, _____, authorize the below named
Client/Legal Guardian
individual(s) to act on my behalf regarding all matters related to Medicaid funded
transportation.*

Name: _____

Relationship to client: _____

Name: _____

Relationship to client: _____

Name: _____

Relationship to client: _____

Signature/Date of Client or Legal Guardian

*This authorization is indefinite unless otherwise noted.