ESPERANZA CENTER
516 West 181ST Street, New York, NY 10033
Tel: 212-928-5810 Fax: 212-740-2053

TRANSPORTATION REIMBURSEMENT PROGRAM
REGISTRATION FORM

Information about the individual in need:

(Last Name)	(First name)	(D.O.B.)	(Gender)

(Address)	(Apt)	(City)	(State)	(Zip Code)

(Medicaid #)	(TABS ID #)	(Social Security #)

Individual's current residence: (Mark only one)

☐ Alone ☐ Foster care home ☐ With family member ☐ Other: ____________________________

Disabilities: (Mark as many as apply)

☐ Intellectual Disability ☐ Autism ☐ Cerebral Palsy ☐ Epilepsy ☐ Neurological ☐ Other:___________

Family Taxable Income:

☐ Under 60,000 ☐ 60-80,000 ☐ 80-100,000 ☐ 100-120,000 ☐ 120-140,000 ☐ Over 140,000

Describe the need for reimbursement:

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Information about the individual's parent/guardian:

(Name – Print)	(Signature)
(Home Telephone)	(Cell phone)
(E-mail Address)	(Date)

Please Note: Reimbursement will not be made until we have received this completed form.