

WHEELS PARA-TAXI REIMBURSEMENT REQUEST

(PLEASE PRINT)

LAST & FIRST NAME: _____ ADA # _____

ADDRESS _____ CITY _____ ZIP _____
 (Reimbursement checks will be mailed to this address)

DATE OF BIRTH _____ PHONE NUMBER: _____ EMAIL: _____

Your reimbursement is 85% of the total taxi fare (meter fare plus up to 15% tip) up to a \$20.00 maximum reimbursement per ride. Your maximum reimbursement per month is \$200.00. Wheelchair accessible taxi surcharge, if applicable, will be reimbursed in addition to the \$20.00 per ride and \$200.00 per month maximums.

DATE	TIME	ORIGIN	DESTINATION	TAXI CO.	RATE YOUR TRIP	IF THE TRIP YOU TOOK BY TAXI WAS NOT AVAILABLE, HOW WOULD YOU HAVE TRAVELLED	METER FARE	TIP	WHEELCHAIR SURCHARGE	TOTAL FARE
					1. Excellent <input type="checkbox"/> 2. Good <input type="checkbox"/> 3. Fair <input type="checkbox"/> 4. Not Good <input type="checkbox"/> 5. Poor <input type="checkbox"/>	1. I would have called Dial-A-Ride <input type="checkbox"/> 2. I would have not made the trip <input type="checkbox"/> 3. I would have asked someone to take me <input type="checkbox"/> 4. Other <input type="checkbox"/>				
					1. Excellent <input type="checkbox"/> 2. Good <input type="checkbox"/> 3. Fair <input type="checkbox"/> 4. Not Good <input type="checkbox"/> 5. Poor <input type="checkbox"/>	1. I would have called Dial-A-Ride <input type="checkbox"/> 2. I would have not made the trip <input type="checkbox"/> 3. I would have asked someone to take me <input type="checkbox"/> 4. Other <input type="checkbox"/>				
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PLEASE DESCRIBE YOUR EXPERIENCE WITH THE TAXI SERVICE:

THE INFORMATION RECORDED ON THIS FORM IS CORRECT TO THE BEST OF MY KNOWLEDGE:

SIGNATURE: _____ **DATE:** _____

PLEASE MAIL OR BRING THIS COMPLETED FORM AND YOUR TAXI RECEIPTS TO:

**Attn: Para-Taxi Program
Wheels/LAVTA
1362 Rutan Drive, Suite 100
Livermore, CA 94551**

Para-Taxi Program expires 6/30/2012