



Client Name _____ Provider Name (only 1 provider per form) _____

Transport Permission and Auto Safety Checklist

Vehicle Year/Make/Model _____

Date of Inspection _____ Performed By _____

Please inspect each item on provider vehicle and initial that it is in working order:

- Working rear turn signals _____ Working front turn signals _____
- Working brake lights _____ Working headlights _____
- Working windshield wipers _____ Working horn _____
- Functional seatbelts _____ Working A/C (cold and heat) _____
- Properly inflated tires (no visible sagging) _____
- Properly mounted car or booster seat (if required) _____

Minimum tire tread depth of 4/32" (can be checked by placing a quarter in tread of tire. If tread reaches Washington's head, there is sufficient tread depth) _____



I have verified the working order of the vehicle to be used to transport my child(ren) receiving services from Absolute HCBS. I will not sign off on this form prior to verifying the working order of all safety functions listed above. I will not allow my child(ren) to have transportation to be provided unless all safety features checked above are in full working condition.

I give my permission for _____ to provide transportation for _____ in his/her vehicle for outings, and to seek medical attention should it be necessary.

Printed Guardian Name _____ Signature _____ Date _____

OR Request to Decline Transportation Services

I am not currently in need of transportation as part of services offered by Absolute HCBS. I understand that my provider may not, under any circumstance, transport. If I should need transportation in the future, I will not allow provider to do so until I have filled out proper paperwork and obtained written permission from Area Manager.

Printed Guardian Name _____ Signature _____ Date _____

I understand that I may not, under any circumstance, provide transportation to this client. If I should need to transport this client in the future, I will not provide transportation until all proper paperwork is completed and I have obtained written permission from my Absolute HCBS Area Manager.

Printed Provider Name _____ Signature _____ Date _____