WAKE COUNTY NORTH CAROLINA Human Services

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www.WakeGov.com

Bus Pass Agreement

As a recipient of this "Bus Pass", I agree to the following conditions regarding use of the Bus Pass:

1. I agree/I understand that the use of the Bus Pass is to provide roundtrip transportation to a Medicaid Approved appointment authorized to **me** from Wake County Medicaid Transportation staff person.
2. I will not permit another person to use the Bus Pass issued to **me**.
3. I will be responsible for the safe keeping of this Bus Pass issued to me and, if lost, I will report its loss immediately to the Wake County Medicaid Transportation Staff that issued the pass to me, by calling 919-212-7005.
4. I agree to return this Bus Pass immediately if I do not use it for the purpose that was authorized.
5. I will submit the **DMA-5118 Medicaid Verification Form** and this signed **Bus Pass Agreement** to the Wake County Medicaid Transportation office immediately after appointment, via fax at 919-212-7667 or by mail using the return envelope provided.
6. I understand that failure to adhere to any of these policies could result in disqualification for further services.

My signature below indicates that I have read this agreement, understand it, and agree to the conditions above.

Bus Pass Recipient Signature: _____ Date: _____