CALIFORNIA ONLY

KHOBCARE TRANSPORTATION
Office of Special Needs Adults
Adults Special Education Program

KHOBCARE YEAR 2021-2022
Must Check One:
( ) 1 TIME ONLY
( ) MONTHLY
( )RE-OCCURRING

KHOBCARE Special Needs Transportation Request Form

Section I – ADULT Demographics

Date: ____________________

Provider Name: ______________________________ **Location:** ______________________________

Adult Last Name: ______________________________ **Adult First Name:** ______________________________

DOB / / **Gender:** Male Female **County Area:**

Section II – Session Time Correction

Start Time: ____________ End Time: ____________

Start Time: ____________ Cannot change from AM to PM or PM to AM End Time: ____________

Note: TO MAKE CHANGES TO THIS FORM PLEASE CONTACT THE OFFICE FOR A NEW FORM, THANK YOU!

Section III – Pick-up and/or Drop-off Location

PLEASE MAKE SURE THIS SECTION IS ACCURATE

If the address needs to be changed in the future, please contact the office for a new form.

Note: We take pride in making sure the safety of all client's come first. Please contact Keola Harris (Owner) with any changes for transportation. Providers cannot accommodate these requests.

Pick-up location Effective Date: ______________________________

Address: ______________________________ City/Town: ____________________ Zip Code: __________

Phone Number: ____________________ Authorized Person(s): ______________________________

Mon.______ Tues.______ Wed.______ Thurs. ______ Fri. .______

Drop-off Effective Date : ______________________________

Address: ______________________________ City/Town: ____________________ Zip Code: __________

Phone Number: ____________________ Authorized Person(s): ______________________________

Mon.______ Tues.______ Wed.______ Thurs. ______ Fri. ______

Section IV – Emergency Drop-Off Information

Authorized Person and Phone contact information must be kept updated if any changes

Address: ______________________________ City/Town: ____________________ Zip Code: __________

Phone Number: ____________________ Authorized Person(s): ______________________________

Section V – Authorized Persons

Add / Delete: Name: ______________________ Add / Delete: Name: ______________________

Add / Delete: Name: ______________________ Add / Delete: Name: ______________________

Section VI – Authorizing Signatures

Responsible Party Signature: ______________________________ Date: ____________________

Intake Representative Authorized Signature: ______________________________ Date: ____________________

KHOBCARE

Provider: Send one copy to Keola immediately;

Humane Resources: Fax form to KHOBCARE at 559-860-0113
4922 E Yale Ave #14 Fresno CA 93727

CALIFORNIA ONLY

KHOBCARE TRANSPORTATION
Office of Special Needs Adults
Adults Special Education Program
KHOBCARE Special NeedsTransportation Request Form

KHOBCARE 2021-2022
School District Must Check One:
( ) One Time Only
( ) Monthly One
( ) Re-occuring

Section I – Adults Demographics

Service Area : ______________________________

Client Last Name: ______________________________ Client First Name ______________________________

DOB / / Gender: Male Female
Provider Name: ______________________________ Location: ______________________________

Section II – Office Use Only

Reason: ___ Adult First Date ____________________ Adult End Date ____/____/____ KHOBCARE-______________

____Does the client live in a Facility and date they started ____/____/_____ Facility: ______________________

_____Other:____of ____/____/_____KHOBCARE-__________________

Section III – Out Of Town Trips ___________

Requires Amended Transportation W/CGSD

Amended Transportation Date Starts on: ____/____/___

A. What types of places does the client enjoy: ______________________________
B. What makes him/her happy when their doing Activities? ______________________________
C. Would you approve of day trips to the beach/ where the distance is not local? ______________________________
D. What item's make him/her feel special; we believe in giving gift's? ______________________________

Section IV– Transportation Session Time

Original Start Time: __________ Original End Time: __________

New Start Time: __________ New End Time: __________

KHOBCARE Session Hours Spent: ______________________________

Section V– Outdoor Behavior Monitoring

Caregiver Notes Based On Outing Behavior

Effective Date: ____/____/___

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Section VI– Progress Notes

KHOBCARE NOTES & EVALUATION

Please inform Client responsible party of our outdoor monitoring reports

Section VII– Change of Pick-up and/or Drop-off

When the home address changes/Or client is being picked up at different location.

New Pick-up location Effective Date of Change: ______________

Address: ______________________________ City/Town: ______________________ Zip Code: _________

Phone Number: ______________________ Authorized Person(s): ______________________________

Mon.______ Tues.______ Wed.______ Thurs. ______ Fri. .______

New Drop-off Effective Date of Change: ______________

Address: ______________________________ City/Town: ______________________ Zip Code: _________

Phone Number: ______________________ Authorized Person(s): ______________________________

Mon.______ Tues.______ Wed.______ Thurs. ______ Fri. ______

Section VIII– Authorizing Signatures

Responsible Party Signature: ______________________________ Date: ______________________

intake Representative Signature: ______________________________ Date: ______________________

Date:

4922 E Yale Ave #14 Fresno , CA 93727
559-780-6646 Fax: 559-860-0113

KHOBCARE