OCTA Reduced Fare ID Card
Assessed Eligibility Form

DATE: _____

TO: **Carlos Andrade, BHS Program Support**
Building #38W

CLIENT NAME: _____ MRN #_____
(Lname, Fname – Please Print Legibly)

CARE COORDINATOR NAME: _____ PHONE # _____
(Name & Tel # – Please Print Legibly)

CLINIC NAME: _____
(I.e. AMHS, CYS, ADAS, etc. then name of clinic)

PSYCHOLOGIST OR PSYCHIATRIST NAME: _____
(PLEASE PRINT FULL NAME LEGIBLY)

* THIS SECTION FILLED OUT BY SERVICE CHIEF *

PLEASE REVIEW FORMS FOR ACCURACY AND COMPLETE CONTENT

I have reviewed this application package for eligibility and it includes the following 3 required documents:

1. **Assessed Eligibility Form (this form filled out completely)**
2. **OCTA Reduced Fare Application (Original Form only; no copies)**
3. **Authorization to Disclose Protected Health Information (PHI) form**

PRINTED NAME: _____ **SIGNATURE:** _____

(PLEASE PRINT & SIGN YOUR NAME ABOVE)

( ) -
(Area Code) Phone Number Date (mm/dd/yyyy)

Allow 5-6 weeks for OCTA to process

*To order more applications or for the status of an application call **Angelina Martinez** at 714-560-5596*