HPC Transportation Mileage Log

Month/Year:		Provider Name:		Provider Contract #	
Ind. Name:		Medicaid #		License Plate #	

Date	Travel Description			Modified Vehicle Rate (Y/N)	Odometer Reading		Total Miles
	Origination	Destination	Reason		Start	Finish	

***Number of individuals transported is 1 unless otherwise stated in notes.**

Provider Signature: _____ Date: _____

HPC Transportation Daily Inspection Checklist

DAILY INSPECTION ONLY REQUIRED ON MODIFIED VEHICLES EQUIPPED TO TRANSPORT INDIVIDUALS WHO REQUIRE USE OF A WHEELCHAIR

DAILY CHECKLIST (check response)		SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	DATE OF SERVICE:							
Permanent Fasteners to secure wheelchair to floor or side of the vehicle		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Safety Harnesses or Seat Belts		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Stable Access Ramp or Hydraulic Lift		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Date problems were fixed:								
I verify that the above equipment is in working condition to safely transport passengers who utilize a wheelchair. Any equipment not meeting this standard will be immediately repaired before use.	Driver's Initials:							

Date	Notes	Initials