

**THE HOUSTON REGIONAL HIV/AIDS RESOURCE GROUP, INC.  
MEDICAL TRANSPORTATION REQUEST FOR WAIVER**

<b>NAME OF SUBGRANTEE:</b>			
<b>SERVICE:</b>			
<b>CONTRACT NO:</b>		<b>CONTRACT PERIOD:</b>	

**WAIVER REQUEST:**

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**(ONE FORM PER CLIENT)**

<b>CLIENT 14-CHARACTER CODE:</b>			
<b>EFFECTIVE DATE:</b>		<b>END DATE:</b>	

**PURPOSE OF THE WAIVER:** describe in detail how the requested waiver will enhance **client services**.

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**SUBMITTED BY:**

\_\_\_\_\_  
*SIGNATURE*

\_\_\_\_\_  
*DATE*

*SUBMIT TO OUTREACH COORDINATOR, AIDS FOUNDATION HOUSTON*

*FOR AIDS FOUNDATION HOUSTON'S USE ONLY*

**DENIED**                       **APPROVED**                       **APPROVED WITH MODIFICATIONS BELOW**

**MODIFICATIONS:**

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*OUTREACH COORDINATOR*

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*DATE*