

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

NAME OF SUBGRANTEE:			
SERVICE:			
CONTRACT NO:		CONTRACT PERIOD:	

WAIVER REQUEST:

(ONE FORM PER CLIENT)

CLIENT 14-CHARACTER CODE:			
EFFECTIVE DATE:		END DATE:	

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

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:

OUTREACH COORDINATOR

DATE