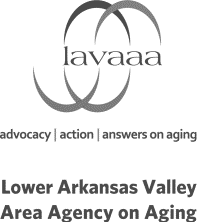
# **Lower Arkansas Valley Area Agency on Aging (LAVAAA) Volunteer Non-Emergency Medical Transportation (NEMT) Program Application**

This form must be completed and signed by the applicant, or parent/guardian to be considered for eligibility, and returned to the Lower Arkansas Valley Area Agency on Aging (LAVAAA), Volunteer Non-Emergency Medical Transportation (NEMT) Program to be considered for eligibility. **Any missing or incomplete information will delay the eligibility determination process and will result in the application being denied until the information is received.**

|  |  |  |  |
| --- | --- | --- | --- |
| Last Name, First Name (**PLEASE PRINT)**: | | Phone Number: | |
| Street Address: | | Mailing Address: | |
| City: | Zip: | City: | Zip: |
| Gender:  \_\_\_\_Male \_\_\_\_Female \_\_\_\_Other | | DOB: | |
| Have you received and read a copy of the Non-Emergency Medical Transportation Client Eligibility and Responsibilities statement? \_\_\_Yes \_\_\_No | | | |
| SSN: \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_ Obtaining Social Security numbers as referenced in THE PRIVACY ACT OF 1974, 5 U.S.C. § 552a, Sec. 7(b) is voluntary and is used by Otero County Department of Human Services to verify the identity of an individual. | | | |
| **Special Needs for Rides: Other Special Considerations:**  \_\_\_Walker - Foldable/Cane \_\_\_Low Vehicle Needed  \_\_\_Wheelchair (\*\*Must be Foldable) \_\_\_High Vehicle Needed  \_\_\_ Oxygen \_\_\_Someone to accompany for medical reasons | | | |
| **FOR MEDICAL DISCHARGE RIDES ONLY:** | | | |
| Medical Staff Verifying the Ride Request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Staff Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_  **LAVAAA/NEMT DRIVER SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **P/U TIME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Do you have Health First Colorado (Medicaid) benefits: \_\_\_Yes \_\_\_No  Do you have Health First Colorado (Medicaid) Transportation benefits: \_\_\_Yes \_\_\_No | | | |
| Are you a VETERAN: \_\_\_ Yes \_\_\_No  \* If yes, you must complete the Statement of Understanding for American Legion Post #9.  Are you enrolled in VA medical benefits? \_\_\_ Yes \_\_\_No (You do not have to be enrolled to use this program)  Are you a resident of Otero, Bent, or Crowley County? \_\_\_ Yes \_\_\_No  \* Veteran applicants must live in Otero, Bent, or Crowley Counties to qualify for LAVAAA/NEMT A.L.#9 funded rides. | | | |
| **ALL APPLICANTS** | | | |
| Are you 59\* years of age or older? \_\_\_ Yes \_\_\_No  \* You must be 60 or older to qualify for AAA funding. We will keep your application on file for one year.  \*You must include a copy of your income verification for AAA & CSBG-funded rides.  **Are you a resident of Otero, Bent, or Crowley County?**  \_\_\_ Yes \_\_\_No | | | |
| **Is your income above OR below the amount shown on the CSBG/AAA Income Chart below?**  **Total Household Size and Monthly Income:**  **Household Size** **Annual Income** **Monthly Income** **Income is above or below the amount shown**  \_\_\_\_ 1 Person in Household: $18,225 $1,568 \_\_\_\_ ABOVE \_\_\_\_ BELOW  \_\_\_\_ 2 Person in Household: $24,650 $2,129 \_\_\_\_ ABOVE \_\_\_\_ BELOW  \_\_\_\_ 3 Person in Household: $31,075 $2,689 \_\_\_\_ ABOVE \_\_\_\_ BELOW  \_\_\_\_ 4 Person in Household: $37,500 $3,250 \_\_\_\_ ABOVE \_\_\_\_ BELOW  \_\_\_\_ 5 Person in Household: $43,925 $3,810 \_\_\_\_ ABOVE \_\_\_\_ BELOW  \_\_\_\_ 6 Person in Household: $50,350 $4,370 \_\_\_\_ ABOVE \_\_\_\_ BELOW  For each additional person in your household, include total number \_\_\_\_ and add $428 per person: $\_\_\_\_\_\_\_\_\_\_\_\_  $\_\_\_\_\_\_\_ Total monthly income of all household members (Optional)  **\*\*All applicants must include a copy of their income verification.**  **Ethnicity:**  \_\_\_ Hispanic, Latino or Spanish Origin \_\_\_ Not Hispanic, Latino or Spanish Origin  **Race: (Multi-Race - Select All That Apply)**  \_\_\_ American Indigenous/Alaskan Native \_\_\_ Middle Eastern/North African  \_\_\_ Asian/Asian American \_\_\_ Native Hawaiian/Pacific Islander  \_\_\_ Black/African American \_\_\_ White    **Highest Grade Completed:** \_\_\_\_\_\_\_  **Marital Status:**  \_\_\_ Single \_\_\_ Domestic Partner \_\_\_ Married  \_\_\_ Divorced \_\_\_ Separated \_\_\_ Widowed  **Housing Status:** \_\_\_Own \_\_\_Rent \_\_\_Homeless  **Do You Live:**  \_\_\_ Alone \_\_\_ With Others \_\_\_ Total # of People in your household (including you)  **Household Type:**  \_\_\_Single Adult \_\_\_Single Parent \_\_\_2 Adults w/No Children \_\_\_2 Parent Household  \_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I do hereby authorize Otero County Department of Human Services to verify my income to determine my eligibility for Community Service Block Grant (CSBG) funds to be used for transportation, and I have included a copy of my income verification along with this application; with the understanding that verification of income is mandatory to determine eligibility for LAVAAA/NEMT funded transportation.  **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **INCOME SOURCES:**  \_\_\_Employment  \_\_\_TANF  \_\_\_SSI  \_\_\_SSDI  \_\_\_VA Service Connected Disability Compensation  \_\_\_VA Non-Service Connected Disability Pension  \_\_\_Private Disability Insurance  \_\_\_Worker’s Compensation  \_\_\_Retirement Income from Social Security  \_\_\_Pension  \_\_\_Child Support  \_\_\_Alimony or other Spousal Support  \_\_\_Unemployment Insurance  \_\_\_Earned Income Tax Credit  \_\_\_N/A (Not Applicable or None of the above)  Other Income Sources: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **NON-CASH BENEFITS:**  \_\_\_SNAP  \_\_\_WIC  \_\_\_LIHEAP (LEAP)  \_\_\_Housing Voucher  \_\_\_Public Housing  \_\_\_Childcare Voucher  \_\_\_Affordable Care Act Subsidy  \_\_\_HUD-VASH  \_\_\_Permanent Supportive Housing  \_\_\_N/A (Not Applicable or None of the above)  Other Non-Cash Benefits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **DISCLOSURES, WAIVERS & CONSENT FOR TRANSPORTATION PROGRAM PARTICIPATION:** | | | |
| *I have been informed of the policies regarding voluntary contributions, complaint procedures, and appeals.* I do not have any means of transportation that is of no cost to the state of Colorado and **I am not eligible for Health First Colorado (Medicaid) transportation benefits.** I do hereby authorize the Otero County Department of Human Services to verify my eligibility for Health First Colorado (Medicaid) transportation benefits. If I am eligible, I understand that I am not eligible for non-emergency medical transportation provided through LAVAAA/NEMT. I am aware that to receive requested transportation services, it may be necessary for LAVAA/NEMT to share information with other departments or service providers, and I herewith give my consent to do so.  There are times that LAVAAA/NEMT staff will determine the need for a shared ride to fulfill open ride requests. I do hereby give my consent to participate in shared rides.  **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **For Office Use Only**  *The above individual has indicated that they receive/qualify for one of the public assistance programs through the Otero County Department of Human Services (OCDHS) and has provided written authorization for the release of the following information:*  State (CBMS) ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health First Colorado (Medicaid) Transportation: \_\_\_Yes \_\_\_No  Total Household Income: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Eligible at or below 125%: \_\_\_Yes \_\_\_ No  Date Eligibility Verified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DHS Staff Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DHS Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is the applicant a Resident of Otero, Bent, or Crowley Counties: \_\_\_ Yes \_\_\_No  *\* Applicants must live in Otero, Bent, or Crowley Counties to qualify for LAVAAA/NEMT CSBG & A.L.#9 funded rides.* | | | |

**Lower Arkansas Valley Area Agency on Aging (LAVAAA)**

**Volunteer Non-Emergency Medical Transportation (NEMT)**

**Emergency Contact Form**

Applicant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Emergency Contact**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like us to share relevant medical information with this person in case of a medical emergency?

Yes No

**Secondary Emergency Contact**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like us to share relevant medical information with this person in case of a medical emergency?

Yes No

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_