# **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.**

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| --- | --- |
| 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 \_\_\_NoTotal Household Income: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Eligible at or below 125%: \_\_\_Yes \_\_\_ NoDate 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_