Eppson Senior Assisted Transportation Services Application for Eligibility

General Information:

The purpose of this application is to provide the Eppson Center for Seniors with the information needed to determine your eligibility category and to obtain contact information we will need to reach you.

Who qualifies and what to submit:

All riders are required to have a completed application on file. Individuals will qualify for transportation services under this program in one of four ways. The application requirements and documentation are different depending on which way you choose to apply. You only need to select the one appropriate for your situation. We will only evaluate your eligibility for the option you select.

Please note: Individuals who qualify as members of the general public pay a higher, unsubsidized rate than Laramie Residents who qualify based on age, disability or pre-qualification for Medicaid Waiver. All rides for members of the general public will be subject to availability based on priority status.

- ☐ **1. I am 60 Years or Older**
  If applying based on age, you need to complete and submit Section 1 of this application along with proof of age (copy of Driver's License, state ID, passport, birth certificate or any other ID with your birthdate on it). Please do not send original documents or anything with your social security number or other sensitive information.
- ☐ **2. I am 18-59 Years old and Have a Disability**
  Individuals who are 18-61 with a disability should submit sections 1 & 2, and potentially section 3. Section 2 will outline the proof of disability requirements. Please do not send original documents or anything with your social security number or other sensitive information.
- ☐ **3. I am pre-qualified for the Medicaid Waiver Program**
  Individuals who are pre-qualified for the Medicaid Waiver program have worked with a case manager who has referred them to our program. Please submit section 1. Rides will not be provided until the "notice of eligibility" is received from the Medicaid waiver program regarding receiving transportation through the Eppson Center. Please do not send original documents or anything with your social security number or other sensitive information.
- ☐ **4. I am Applying Under the General Public Provision**

If you are a member of the general public and are under 60 years of age; you do not have a disability; or pre-qualify for the Medicaid Waiver Program you must complete section 1 only. Please remember all rides will be subject to availability.

Submitting an application:

Send completed application to:

The Eppson Center for Seniors
c/o Transportation Department
1560 North 3rd Street
Laramie, WY 82072

Other guidance:

Please note that the Eppson Center will not find any person whose sole incapacity is pregnancy, obesity or drug/alcohol addiction eligible based on disability.

Applicant's financial circumstances are not considered. Please do NOT submit financial or other sensitive personal information not requested here.

If your application is not complete, it will be returned to you if possible, and you will be notified of what is missing. You will be notified by mail to provide the address (if provided) of any eligibility determinations. The Eppson Center is unable to process applications that are not complete.

For assistance in filling out your application, please call 307-745-5116.

Starting April 1, 2020, the Eppson Senior Assisted Transportation Service will only provide transportation to individuals who have completed our application and have received their eligibility card.

The Eppson Center for Seniors operates its programs and services without regard to race, color or national origin in accordance with Title VI of the Civil Rights Act.

ELIGIBILITY APPLICATION FORM – Section 1

A. Personal & Emergency Notification Information

First Name_____ MI_____ Last Name_____

Home Address_____ Apt._____ Zip _____

Cross Streets_____ & _____

Cell Phone #_____ Home Phone #_____

Email Address _____

Date of Birth ____/____/_____ Gender: □ Male □ Female □ Prefer not to answer

Are you a Medicaid Waiver client/recipient? □ Yes □ No

Have you served in the Military? □ Yes □ No

Mailing Address: (If different from above)

Address_____ City_____ State_____ Zip_____

Emergency Contact:

Name_____ Relationship _____

Home Phone # _____ Cell Phone # _____

Email Address_____

B. Basis for Eligibility

□ I am 60 years or older (Complete Section 1 & provide proof of age)

□ I am 18-59 years old and have a disability (Complete Sections 1, 2 & 3)

□ I pre-qualify under the Medicaid Waiver Program (Complete Sections 1)

Case Manager: _____ Phone #:_____

□ I am applying under the general public provision (Complete Section 1)

C. Accessibility Information

1. Do you have any physical or functional limitations? □ Yes □ No

If yes, please describe_____

2. Do you require a mobility device or special equipment for transport? □ Yes □ No

If yes, please check all that apply:
□ Cane □ Walker □ Service Animal □ White Cane □ Prosthesis
□ Oxygen □ Manual Wheelchair □ Powered Wheelchair/Scooter
Other_____

If yes, are you able to enter/exit the vehicle without your mobility device? □ Yes □ No

3. Will you need to travel with a Personal Care Attendant (PCA)?

□ Always

□ Sometimes

□ Never

A PCA can be any person, including a child 12 or older, whom you need to help you get from your home to the vehicle, get on or off the vehicle, or assist you at your destination. No special training is needed to be a PCA. **The Eppson Center does NOT supply PCAs**. PCAs will ride for FREE with an eligible rider.

4. Please list your primary doctor(s) name & address:

_____

_____

_____

5. How often do you anticipate needing to use the transportation service?

□ Weekly □ Monthly □ Other _____

□ **I have received a copy of the Rider Agreement & Frequently Asked Questions and I understand it is my responsibility to read and follow the agreement as outlined.**

I understand that the purpose of this application is to determine my eligibility to use the Eppson Senior Assisted Transportation Services and I agree to release the information herein to the Eppson Center. I understand that the Eppson Center reserves the right to request additional information needed for this evaluation.

I have attached a copy of a valid identification with my printed date of birth to this application.

I certify that the information in this application is true and accurate. I understand that falsification of the information may result in denial of service. I understand all information will be kept confidential, and only the information required to provide the services I request will be disclosed to those who perform those services. I understand that the Eppson Center may contact the health care professional who has completed Section 3 to confirm this information.

Applicant's Signature_____ Date_____

ELIGIBILITY APPLICATION FORM – Section 2

This section only needs to be completed by individuals applying on the basis of disability.

Applicant's
First Name _____ MI_____ Last Name _____

A. Disability Status

☐ **Temporary**

Your disability is expected to last up to one year. If you are found eligible, your eligibility will expire on a particular date. If your disability lasts longer, you will need to re-apply to continue receiving service.

☐ **Long-Term**

Your disability is expected to last for at least one year, but there is a chance of improvement or long periods of remission. If you are found eligible, your eligibility will expire one year after your initial approval. You will need to re-apply annually to continue receiving services. All applications based on mental impairments, Medicare or Social Security disability are considered long-term applications.

☐ **Permanent**

This status is appropriate for those with a disability that will never significantly improve (for example, an amputation or a developmental disability). If you are found eligible, you will never have to re-apply unless you move out of Laramie and then return at a later date.

B. Proof of Disability

Please indicate which type of proof of disability you are submitting. Only one type of proof is necessary.

☐ **I have been found at least 70% disabled by the Veteran's Administration**. Please attach a copy of a letter signed by a Veteran's Service Officer that specifies your disability rating. You do NOT have to have a health care professional complete Section 3.

☐ **I have a Medicare Card.** Please attach a copy of the card. You will have to confirm every year that you continue to have Medicare. Please do not send original documents. If you want to apply for permanent status instead, you will need to have a health care professional complete Section 3.

□ **I have been found disabled by the Social Security Administration**. Please attach proof of receipt of SSI or SSDI benefits, such as a copy of a bank statement. You may attach a copy of an award letter, but it must be dated within six (6) months of the application. Unless you have been determined to be permanently disabled, you will have to confirm every year that you continue to receive SSI or SSDI benefits. If you want to apply for permanent status instead, you will need to have a health care professional complete Section 3.

□ **I have been determined by a Community Mental Health Provider (CMHP) to have a severe mental illness (SMI) or severe and persistent mental illness (SPMI), or I am currently in the intake process during which this determination will be made.** You must provide copies of documentation of this determination. If you want to apply for temporary or permanent status instead, you will need to have a health care professional complete Section 3.

□ **None of the above applies, but I have a qualifying disability.** You will need to have a health care professional fill out Section 3.

ELIGIBILITY APPLICATION FORM – Section 3

This section only needs to be completed by individuals applying on the basis of disability, and who do not have other acceptable proofs of disability or wish to qualify for temporary or permanent disability status.

Applicant's
First Name _____ MI_____ Last Name _____

Section 3 must be completed by one of the following health care professionals who is familiar with the applicant's condition:

Physician Physician Assistant Psychologist
Social Worker Respiratory Therapist Psychiatrist
Physical Therapist Nurse Practitioner Audiologist
Optometrist/Ophthalmologist Registered Nurse

Your patient _____ has applied for disability status through Eppson Senior Assisted Transportation Services. If found qualified, this individual will be able to utilize Eppson Senior Assisted Transportation Services as an individual with a disability who is under the age of 60.

Disability status under the Eppson Senior Assisted Transportation Services Program is for people who have a physical or mental impairment (condition) that preclude them from riding in vehicles that do not have any accessibility features, such as a typical car, truck or SUV. Eligible clients are generally picked up outside their homes at or near a requested time and taken directly, or indirectly, to their destination.

Eligibility is a functional determination, not a medical one, individuals qualify if they have a specific Condition that prevents them from riding in a typical automobile.

Please keep in mind that the following skills may be necessary for the effective use of the Eppson Senior Assisted Transportation Services:

- ✓ Handling money
- ✓ Sitting in a moving vehicle
- ✓ Reading information signs
- ✓ Hearing announcements by vehicle operators
- ✓ Navigating and being aware of when it is time to meet or get off the vehicle

The conditions listed on the following pages would limit the ability to perform these tasks as effectively as other people without special considerations/modifications (for example a wheelchair lift/ramp).

Please note that the Eppson Center will not consider any person whose sole incapacity is pregnancy, obesity, or drug/alcohol addiction.

1. **I am familiar with the applicant's physical/mental condition.** □ Yes □ No

2. **This applicant's disability is (please choose one):**

□ Temporary

The disability is expected to last between 3 months to one year.

Expected period of disability: _____

Please be specific, as this information will be used to determine the length of time for which the temporary eligibility card is valid.

□ Long-Term

The disability is expected to last for at least one year, but there is hope of improvement or long periods of remission. All applications based on mental impairments are considered long-term applications.

□ Permanent

The disability will never significantly improve (for example, an amputation or a developmental disability). If the applicant is found eligible, he or she will be automatically issued a new eligibility card every year without need for re-application.

3. In my professional opinion, this applicant is (please choose one):

□ A. **Non-Ambulatory Disabled**

The applicant cannot walk, even with assistance of devices (e.g. walker, crutches, cane, brace, prosthesis, etc…), but has sufficient personal mobility and independence in a wheelchair that the use of fully accessible public transportation is a reasonable expectation.

□ B. **Semi-Ambulatory Disabled**

The applicant cannot walk more than a very short distance without the assistance of a walker, crutches, cane, brace, prosthesis, or other such

adaptive device, and the use of fully accessible public transportation is a reasonable expectation.

□ C. **Otherwise Disabled from a Transit Perspective**

If you chose C for Question 3, please check any of the following conditions that apply to this applicant.

□ Hearing disability (total deafness or hearing loss 90db or greater in the 500, 1000, 2000 Hz ranges despite hearing aids)

□ Vision disability (vision in the better eye is no better than 20/200 after correction, or visual field is contracted)

□ Progressive, debilitating illness that significantly impairs mobility, with chronic symptoms such as pain, fatigue, weakness, or mental status changes (e.g., AIDS, cancer, lupus, etc.)

□ Pulmonary or cardiac disability shown by X-ray, EKG or other tests, and resulting in breathlessness, pain or fatigue despite treatment

□ Faulty coordination from a brain, spinal, or peripheral nerve injury or arthritis

□ Loss or absence of both hands, or loss of major function of both hands

□ Dependency on kidney dialysis to live

□ Cerebrovascular accident (stroke) with persistent physical effects

□ Neurological disability that is not controlled by medication (e.g., epilepsy, multiple sclerosis, etc.)

□ Developmental disability originating before age 22 (e.g., cerebral palsy, autism, Down's syndrome, etc.)

□ Psychiatric disability recognized by the DSM IV and severe enough to cause limitations of daily life functioning

□ Other. Please attach information about the applicant's diagnosis and its effects relating to the use of public transportation.

I hereby certify that the above information is accurate and true to the best of my knowledge.

Signature of Medical Professional:_____

Printed Name and Title: _____

Date: _____ Phone Number:_____

Address: _____

AUTHORIZATION OF RELEASE
FOR MEDICAL INFORMATION

TO BE COMPLETED BY APPLICANT AND PROVIDED TO YOUR HEALTH CARE PROVIDER

Dear Health Care Professional:

I _____ have applied to Eppson Senior Assisted Transportation Services to be certified as eligible for the program as an individual under the age of 60 with a functional disability. Part of this application process requires a health care professional (see list on page 7) to review the information I have provided. I hereby authorize you to provide this information by completing Section 3 of the Eligibility Application Form and to discuss it with the Eppson Center Staff.

I have completed Section 1 & 2 of this application and have attached Section 3 for your use.

Signature: _____ Date: _____

Name (Please print): _____