Western Placer CTSA Consolidated Transportation Services Agency

HEALTHEXPRESS

Health Express Eligibility Application

Beginning July 1, 2015, every Health Express rider will have to be certified as eligible to use this program before their trip requests will be accepted by the Call Center. The eligibility criteria have not changed: to use the Health Express program, an individual must be:

A resident of Placer County
and either: 1. 60 years of age or older;
or 2. Disabled.

The new Health Express eligibility process requires that individuals provide documentation of their eligibility before they request a ride, making the reservation process more efficient and convenient for all riders.

Here's how to initiate your Health Express eligibility certification:

STEP 1 – Complete the Health Express Eligibility Application.
The Application Form should be filled out by the applicant or the applicant's representative. The form must be completely filled out and signed by the applicant or, if the applicant is less than 18 years of age, the application must be signed by the applicant's legal guardian.

Make sure the application is complete. An incomplete application will delay your certification.

STEP 2 - Mail your completed Application with copies of the requested documentation to:

Seniors First – HE Applications
12183 Locksley Lane, Suite 205
Auburn, CA 95602

Or bring your completed Application to the Seniors First office and we'll review your application and supporting documentation while you wait.

Do you have questions or want to complete your application by phone or in person?
Call Seniors First at (530) 889 – 9500, extension 220 or by email at Jenny@seniorsfirst.org.

Office Use Only:
New ____ Recert ____

HEALTH EXPRESS ELIGIBILITY APPLICATION

Part 1. General Information

Last Name _____ First Name _____Middle Initial __

Address _____ Unit #_____

City _____State _____ ZIP _____

Phone - Home (____) ____-_____ Phone – Alt (____) ____-_____

Cell Phone (____) ____- _____ E-Mail_____ @_____

Emergency Contact Name _____ Phone (____) ____- _____

Date of Birth _____/_____ /_____

Part 2. Residency

Individuals must be residents of Placer County to use the Heath Express Program. Please provide one of the following to document your Placer County residence:

Check which is provided: ☐ Driver's License or State ID Card
☐ Utility Bill
☐ Other: _____

Part 3. Age or Disability Information

In addition to being residents of Placer County, individuals must also be either 60 years of age or older or disabled to use the Health Express Program.

1. **Senior Eligibility**: If you are 60 years of age or older, please provide one of the following to document your age:

Check which is provided: ☐ Driver's License or State ID Card
☐ Medicare Card
☐ Other: _____

2. **Disabled Eligibility**:

A. Please provide a description of your disability:

_____

_____

B. How does your disability affect your ability to use public transit?

_____

_____

C. Is your disability described above? (check only one)

☐ Permanent
☐ Temporary If temporary, how long do you expect it to last? ____ months.
☐ I don't know

D. Does your disability change from day-to-day under certain circumstances?

☐ No ☐ Yes How?

_____

E. Do you ***require*** a Personal Care Attendant (PCA) to travel with you to destinations outside of your home?

☐Always ☐Sometimes ☐Never

F. Do you travel with a Service Animal[1]?

☐Always ☐Sometimes ☐Never

G. Rider Supervision:

1) Are you able to ride safely without supervision other than the driver?
☐ Yes ☐ No

2) Can you be left unsupervised at your trip destination?
☐ Yes ☐ No

H. Do you require special assistance to or from the vehicle in order to use Health Express?
Check all that apply.

☐ I need special assistance from my residence to the Health Express vehicle.
☐ I need special assistance from the Health Express vehicle to my destination.

I. Which of the following mobility aids or equipment do you use when traveling to destinations outside of your home?

☐None	☐Walker	☐White Cane
☐Manual Wheelchair	☐Cane	☐Service Animal
☐Electric Wheelchair	☐Crutches	☐Portable Oxygen
☐3 or 4-Wheel Scooter	☐Leg Braces	☐Prosthesis

☐Other (please specify) _____

[1] "Service Animal" means any guide dog, signal dog, or other animal individually trained to work or perform tasks for an individual with a disability, including, but not limited to, guiding individuals with impaired vision, alerting individuals with impaired hearing to intruders or sounds, providing minimal protection or rescue work, pulling a wheelchair, or fetching dropped items. [49 CFR Part 37, Subpart A, Section 37.3]

!! IMPORTANT NOTE !!

Health Express cannot guarantee its ability to transport you if your wheelchair/scooter is longer than 48 in., wider than 30 in., or if your total weight including wheelchair is more than 600 pounds. Transport over these dimensions will be determined by lift and vehicle capabilities.

Health Express eligibility may be granted on the basis of disability by submitting either acceptable evidence of disability certification by another agency or a signed certification of your disability by a medical or health care professional.

Disability Documentation: Please provide any one of the following to document the certification of your disability by another agency or complete the attached Health Express Disabled Certification Form.

Check which is provided:

- ☐ Current ADA Paratransit Certification Documentation
- ☐ Current SSI/SSDI award letter
- ☐ Valid California DMV Disabled Placard receipt
- ☐ Dept. of Veteran's Affairs documentation of service connected disability
- ☐ Current Transit Discount ID for Disability
- ☐ Other: _____

If you are able to provide any one of the above-listed documentations of your disability, SKIP Part 4 and continue this application with Part 5.

Part 4. Health Express Disabled Certification Form

Information to be completed by Applicant:

Applicant's Name: _____ Applicant's Data of Birth: _____

I hereby authorize the person listed below to release to Seniors First/Health Express medical or other pertinent information about my disability. The information released will be solely used to determine my eligibility for Health Express services.

_____ _____
Signature Date

Information to be completed by a Health Care Provider, Social Worker or Counselor who represents a recognized organization for persons with disabilities

The above named individual is applying to use the Health Express non-emergency medical transportation services. Health Express service is available to Placer County residents who are 60 years of age or older or disabled, as defined in federal regulations:

> "disabled" shall mean an individual who, by reason of illness, injury, congenital malfunction, or other permanent or temporary incapacity or disability, including those who are nonambulatory wheelchair-bound and those with semi-ambulatory capabilities, is unable without special facilities or special planning or design to utilize mass transportation facilities and services as effectively as persons who are not so affected. [49 CFR Part 609 Subsection 609.3]

To process this request, please provide the following information:

Give a description of this individual's disability:

_____

_____

How does this disability affect the applicant's ability to utilize public transportation?

_____

_____

Is this disability [___] Permanent (conditions with absolutely no expectation of improvement)

Or [___] Temporary (expected duration from _____ to _____)

I certify that _____ meets the eligibility criteria as transportation disabled.

Name: _____ License #: _____

Organization: _____ Phone Number: (_____) ____-_____

Organization Address: _____

City: _____ ZIP: _____

I declare under penalty of perjury under the laws of the State of California that the information I have given is true and correct.

_____ _____

Signature **Date**

Part 5. Signature

A. Applicant's Signature

I understand that the purpose of the Application is to determine if I am eligible for non-emergency medical transportation through the Health Express Program. I certify that the information I gave in this application is true and correct and that the Application will be returned to me if not complete, which delays processing. I understand that falsification or misrepresentation of facts may result in denial of service. I understand that additional information from my healthcare professional related to my disability or medical condition may be required to help determine my eligibility and approve the release of such information by the named professional for this purpose.

Signature of Applicant: _____ Date: _____
(Applicants must be 18 years of age to sign independently. Otherwise, the signature of a guardian is required.)

B. Applicant's Representative

If someone other than the applicant has completed this Application, the following information must be provided:

Name: _____

Daytime Telephone Number: _____

Relationship to Applicant: _____Date: _____