

# Portsmouth Senior Transportation

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## Application for Eligibility

### General Information

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

### Other Formats

If you need this document in large print or to be read aloud for you, please ask COAST for assistance by calling (603) 743-5777 ext. 108.

### Who Qualifies and What to Submit

Individuals will qualify for services under this program in one of three 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 that individuals who qualify as members of the general public pay a higher, unsubsidized rate than Portsmouth residents who qualify based on age or disability.*

**I am 62 Years Old or Older**

If applying based on age, you need to complete and submit Section 1 of this application, along with proof of age. You do not need to complete Section 2 or 3. Proof of age could be a copy of a driver's license or other ID with birth date on it. Please do not send original documents or anything with your social security number or other sensitive information.

**I am 18 – 61 Years Old and Have a Disability**

Individuals who are 18 – 61 with a disability should submit Sections 1 and 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.

**I am Applying Under the General Public Provisions**

If you are a member of the general public and are under 62; you do not have a disability; or are not a Portsmouth, NH resident you must complete Section 1 only.

## Submitting an Application

Send the completed application to:

**COAST**  
**c/o Demand Response Assistant**  
**42 Sumner Drive**  
**Dover, NH 03820**

## Other Guidance

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

Applicants' 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 the provided address (if provided) of any eligibility determinations. COAST is unable to process applications that are not completed.

For assistance in filling out this application, please call COAST's Demand Response Assistant at (603) 743-5777 ext. 108 between the hours of 8:00 AM and 5:00 PM, Monday through Friday.

# ELIGIBILITY APPLICATION FORM – SECTION 1

## TO BE COMPLETED BY THE APPLICANT

### A. Personal and Emergency Notification Information

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Name of Apartment or Neighborhood (if applicable) \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender  Male  Female  Prefer not to say

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Email Address \_\_\_\_\_

Are you a Medicaid client/recipient?  Yes  No

Have you ever 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 62 years old or older.
- I am 18 – 61 years old and have a disability.
- I am applying under the general public provisions.

## SECTION 1 Continued

### C. Accessibility Information

1. Which of these mobility aids or equipment do you use to help you get to where you need to go?

**Check all that apply**

- None                       Walker                       Manual Wheelchair
- Crutches                       Prosthesis                       Powered Wheelchair/Scooter
- Cane / White Cane                       Service Animal                       Other \_\_\_\_\_
- Oxygen

2. If you use a manual or powered wheelchair or scooter, the following information is required:

Length \_\_\_\_\_ (inches)                      Width \_\_\_\_\_ (inches)

Weight \_\_\_\_\_ (lbs. – combined between the individual and device)

**\* If you estimate that the combined weight is more than 700 pounds, please attach documentation of the actual combined weight.**

3. If you are found to be eligible for this service, you will:

- be able to meet the vehicle at the curb
- need assistance from the door of your pick-up point to the vehicle
- need assistance from the vehicle to the door of your destination

4. 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. COAST does not supply PCAs.*

## SECTION 1 Continued

### TO BE COMPLETED BY THE APPLICANT

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

I certify that the information in this application is true and accurate. I understand that falsification of 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 COAST may contact the health care professional who has completed Part III in order to confirm this information.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

### **IF SOMEONE OTHER THAN THE APPLICANT COMPLETED THE APPLICATION:**

I certify that the information provided in this application is true and accurate based upon the information given to me by the applicant and my knowledge of the applicant's physical disability and/or mental impairment.

Name (*please print*): \_\_\_\_\_

Signature: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Does the applicant have a Guardian or Power of Attorney for Health Care (POA-HC)?

Yes       No

***If yes, please provide supporting legal documentation (the POA-HC or Guardianship Orders)***

Name of Guardian or POA-HC: \_\_\_\_\_

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

Phone: (\_\_\_\_) \_\_\_\_\_

## ELIGIBILITY APPLICATION FORM – SECTION 2

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

### 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 services.
- 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 on August 1<sup>st</sup> each year. 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 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 reapply unless you move out of Portsmouth 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. 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 temporary or permanent status instead, you will need to have a health care professional fill out Section 3.

## SECTION 2 Continued

- 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 fill out 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.

### C. Physical or mental impairment information

COAST uses vehicles with a variety of accessibility features, including vehicles that are wheelchair accessible. This information is used in part to determine which vehicles will best meet your needs.

5. Please identify all conditions that affect your ability to ride in an automobile with no accessibility features.

Example:

**Condition:** Multiple Sclerosis (MS) – confined to a wheelchair

**Effect:** Cannot get in and out of a car

**Condition:** \_\_\_\_\_

**Effect:** \_\_\_\_\_

**Condition:** \_\_\_\_\_

**Effect:** \_\_\_\_\_

**Condition:** \_\_\_\_\_

**Effect:** \_\_\_\_\_

6. Is your condition temporary?

No       Yes, expected end date \_\_\_\_\_

I don't know

## SECTION 3

### TO BE COMPLETED BY A MEDICAL PROFESSIONAL

*This section is only required for people applying based on disability, and who do not have other accepted proofs of disability or who wish to qualify for permanent disability status.*

Your patient \_\_\_\_\_ has applied for disability status through COAST. If found qualified, this individual will be able to utilize Portsmouth Senior Transportation services as an individual with a disability who is under the age of 62.

Disability status under the Portsmouth Senior Transportation 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 your typical car, truck or SUV. Eligible clients are generally picked up outside their homes at or near the 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 Portsmouth Senior Transportation services:

- handling money
- getting on and off a standard vehicle
- sitting on a moving vehicle
- reading information signs
- hearing announcements by vehicle operators
- navigating and being aware of when it is time to get off the vehicle
- pulling the cord to signal the operator to stop the vehicle

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

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

1. I am familiar with \_\_\_\_\_'s physical/ mental condition.

- Yes
- No



## SECTION 3 Continued

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

**Temporary**

The disability is expected to last between 3 months and 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 the 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 the 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**

## SECTION 3 Continued

**4. If you chose C for Question 3, please check any of the following 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.*

## SECTION 3 Continued

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

Must be licensed or certified:

Physician

Social Worker

Respiratory Therapist

Psychiatrist

Nurse Practitioner

Registered Nurse

Physician Assistant

Psychologist

Physical Therapist

Audiologist

Optometrist/Ophthalmologist

**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:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone number:** \_\_\_\_\_

**Fax number:** \_\_\_\_\_

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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

Dear Health Care Professional:

I have applied to COAST to be certified as eligible for the Portsmouth Senior Transportation Program as an individual under 62 with a functional disability. Part of this application process requires a health care professional (see list on page 11) to review the information I have provided. I hereby authorize you to provide this information by completing Part III of the application and to discuss it with COAST staff.

I have completed Part I and II of this application and have attached it to Part III for your use.

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

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

Name (*please print*): \_\_\_\_\_