Coshocton Public Transit
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Client Registration / Reduced Fare E&D Application/ Title IIIB AAA9 Form

If you are applying for an E&D Half-price fare card you must submit proof of age or disability.

1. First Name_____ MI_____ Last Name_____

2. Date of Birth _____ / _____ / _____

3. Are you Elderly (age 60+)? ◯ Yes ◯ No 3a. If you are Age 60+, please turn over ⇨

4. Gender: ◯ Male ◯ Female ◯ Unspecified 5. Language: ◯ English Other:_____

6. Mobility (Please check one):

   ☐ Ambulatory (Can walk and use steps to enter vehicle)

   ☐ Wheelchair: ◯ Power ◯ *Manual *Can you transfer into a seat? ◯ Yes ◯ No

   ☐ Cannot use steps, but ***CAN*** get into a mini-van/SUV

   ☐ Cannot use steps and ***CANNOT*** get into mini-van/SUV

7. Race/Ethnicity: ◯ Caucasian (White) ◯ Native American ◯ Asian ◯ Hispanic ◯ African American

8. Do you live alone? ◯ Yes ◯ No 9. Is your income less than $1,300/month? ◯ Yes ◯ No

10. Phone#: (_____) _____-_____ 10a. Alt. Phone# (_____) _____-_____

11. Social Security#: _____ - _____ - _____ 12. Medicaid # (if applicable) _____

13. Are you considered Disabled by a Medical Professional? ◯ Yes ◯ No

14. Special Assistances (Please check all that apply):

    ☐ Blind ☐ Cane ☐ Hearing Impaired ☐ Oxygen ☐ Walker ☐ Other: _____

15. Home Address: _____

    City:_____ State: _____ Zip:_____ County:_____

16. Emergency Contact Name: _____ Phone#: (_____)_____-_____

    Relationship to you: _____

All information is true and correct to the best of my knowledge. I understand that any information provided may be shared with any other department/funder in support of CPT provided services to ensure CPT is compliant with State and Federal Agencies monitoring requirements. If needed, I authorize CPT to verify any information provided.
I HAVE ATTACHED A COPY OF PROOF OF MY AGE/DISABILITY IN ORDER TO RECEIVE AN E&D CARD, IF APPLYING FOR ONE.

Client Signature_____ Date _____

Office Signature_____ Date _____

For Office Use Only

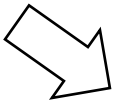
Date Received _____ / _____ / _____ Staff Signature _____ E&D? Yes – Card#_____ No

Title IIIB/AAA9 Disclosure Statement

The attached participant registration form was developed to assist the Ohio Department of Aging to monitor the effectiveness of senior programs offered to the citizens of Ohio. Any participant information obtained from this form will be kept confidential and no personal identifying information (e.g., Name, address, telephone number, ID no., etc) will be released to the public without your expressed written consent, or unless otherwise required under Federal Law.

The data collected (age, sex, race, low-income status, ADL's and IADL's) will be forwarded to the Area Agency on Aging and the Ohio Department on Aging in order to keep both State and Federal Legislators informed on the effectiveness of Senior programs (as required by the 1992 Older Americans Act Reauthorization.) While all participants receiving services under the Older Americans Act are asked to complete the attached form in full, no participant may be denied services for refusing to provide any of the information requested, including social security number.

If you have any further questions, do not hesitate to ask the staff why this release is necessary.



RELEASE OF INFORMATION:

Please initial beside both 1. and 2. and sign at bottom

1. I authorize the information contained in this participant registration assessment form to be used for the purpose of planning or to obtain services to meet my need(s).

2. I authorize release of information to any entity specified by State or Federal laws, HCFA, ODHS, ODA, AAA or any agencies necessary for the purpose of monitoring and/or evaluation.

INFORMATION RECEIVED:

- ✓ Complaint and grievance procedure
- ✓ Participant Rights
- ✓ Participant Financial Responsibility, if applicable
- ✓ Long Term Care Ombudsman Contact Telephone Number
- ✓ Telephone Number of Administrator of Agency Delivering Service(s)
- ✓ Telephone Number of Director of Area Agency on Aging
- ✓ Copy of Service plan, if applicable
- ✓ HIPAA Procedures

I GIVE CONSENT TO RECEIVE SERVICES:

_____

Participant's Signature Date

I have discussed/read/explained the Disclosure Statement with the client:

_____

Employee Signature Date