



Dear Applicant,

Thank you for your inquiry into the City of St. Peters' Transportation Services Program. This program offers transportation for necessary medical, shopping and essential services. The Transportation Program is available to residents of the city who meet the criteria and require transportation services. In order to be considered for the program, an applicant must:

- Individual must reside within the corporate city limits of St. Peters.
- Individual must lack access to a vehicle or be unable to drive.
- Individual is elderly, or severely disabled, or the total household income from all occupants is equal to or less than 80% of the median household income as defined and published by HUD.

In order to determine your eligibility for the program, please check one of the following and provide back up information for that item:

___ I am age 62 or older. **(Please provide copy of birth certificate or identification showing birth date)**

___ I am disabled based on the HUD Section 504 regulation which defines an individual with a disability as any person who has a physical or mental disability that substantially limits one or more major life activities; has a record of such an impairment; or is regarded as having such an impairment (24 CFR 8.3). Major life activities include walking, talking, hearing, seeing, breathing, learning, performing manual tasks, and caring for oneself. The law also applies to individuals who have a history of such impairments as well as those who are perceived as having such an impairment. **(Proof of the disability is required prior to acceptance into the program. Please include a doctor's note or letter from the Division of Social Security regarding the disability as well as income information.)**

___ Based on 2010 Federal Taxes **(Proof of income is required. Please include Federal Tax Statement with backup information.)**

1 Person HH \$38,950, 2 Persons HH \$44,500, 3 Persons HH \$50,050, 4 Persons HH \$55,600, 5 Persons HH \$60,050, 6 Persons HH \$64,500, 7 Persons HH \$68,950, 8 Persons HH \$73,400.

Please complete the following documents:

1. The enclosed Participant Information form
2. The enclosed Declaration form
3. The enclosed Release form
4. The enclosed Eligibility form
5. The enclosed Authorization to Disclose Health Information

Please submit your application materials in the enclosed envelope by mail or in person to:

**City of St. Peters
Attn: Dept. of Community Projects
P.O. Box 9
St. Peters, MO 63376**

Please allow up to two weeks for a response from the city on acceptance into the program. If you have any questions, please call the Community Projects Office at 636-477-6600, Ext. 1366 or Ext. 1204.

Chris Cattoor
SSS Administrative Coordinator

DECLARATION

The undersigned acknowledge that participation in the Transportation Program is voluntary.

The undersigned hereby apply for participation in the Transportation Program as administered by the City of St. Peters and agree to provide the City with the information requested on the Participant Information Form, the Eligibility Certification and all other information requested by the City.

The undersigned further agree to comply with all program conditions, including, but not limited to, compliance with all applicable federal, state, county, and/or city requirements pursuant to the Housing and Community Development Act of 1974, as amended.

The undersigned hereby authorize the City to obtain the documents necessary for participation in the Transportation Program, including title information, income verification, etc.

The undersigned affirm and acknowledge that any misrepresentation of material facts or the failure to produce any requested information may result in a declaration of non-eligibility or a termination of continued participation in the program and a consequent denial of any and all benefits.

The undersigned further represent and warrant that the information that has been given is true and complete to the best of their knowledge.

The undersigned further affirm and acknowledge that they have been notified of and understand their rights and responsibilities as applicants for the Transportation Program.

I hereby certify that all the information stated herein, as well as any information provided in the accompaniment herewith, is true and accurate.

Warning: HUD will prosecute false claims and statements. Convictions may result in criminal and/or civil penalties. (18 U.S.C. 1001, 1010, 1012; 31 U.S.C. 3729, 3802)

RIDER

DATE

RIDER

DATE

SSS ADMINISTRATIVE COORDINATOR

DATE

RELEASE

This release is made and entered into this _____ day of _____, 20____, by and between _____, hereinafter referred to as “Rider”, and the City of St. Peters (hereinafter referred to as the “City”).

In consideration of the Rider’s voluntary participation in the City of St. Peters Transportation Program, the Rider hereby releases and agrees to indemnify and hold harmless the City, its agents, employees, and officers from all claims, damages or causes of action (including reasonable attorneys fees) caused by or arising in any manner from the Rider’s participation in the City of St. Peters Transportation Program and any agreements between the Rider and the transportation provider.

I, the Rider, have read this release and understand all its items. I execute it voluntarily and with full knowledge of its significance the day and year first written above.

RIDER

DATE

RIDER

DATE



Discrimination is prohibited on the basis of race, color, religion, sex, handicap, familial status or national origin.

**CITY OF ST. PETERS
2011-2012 TRANSPORTATION SERVICES PROGRAM**

PARTICIPANT INFORMATION

Applicant Name _____

Address _____ Zip Code _____

Phone: Home _____ Business/Cell _____

Is anyone else living in your home also applying for the program? _____

If yes, please list name _____

Please briefly describe the services that you require:

Please complete the following:

I am ambulatory and require no assistance _____

I need assistance in and out of the vehicle _____

I need assistance from my door, into and out of the vehicle, and up to the door at my destination. _____

I cannot sit and need to be transported in a reclined position _____

I use a cane _____

I use a walker _____

I use a wheelchair _____ if yes, do you weigh over 200 lbs.? _____

Do you have a wheelchair ramp? _____

Do you have outside steps from your front door _____ how many steps? _____

I will use the transportation services primarily for:

_____ medical (hospital, doctor offices or other medical facilities, pharmacy, etc.)

_____ essential shopping (Grocery store, Walgreens, Target/Walmart, Mid Rivers Mall, etc.)

_____ other (briefly describe) _____

Will anyone accompany you? _____

If yes, how many persons? _____ **Are they over the age of 18?** _____

Do you currently drive or have access to a vehicle? _____

Do you have any unusual transportation needs? _____

If yes, briefly explain: _____

Do you have any special medical conditions or disabilities that we should be aware of? _____

If yes, please explain: _____

Are you currently enrolled in the St. Peters Transportation Program? _____

Are you currently enrolled in any other transportation programs (Delta, Star, Oats)? _____

If yes, please list which one(s) you currently use: _____

Emergency Contact Information- please complete (family, friend, neighbor, etc.)

Whom may we contact in the event of an emergency:

Name: _____

Address: _____

Phone: Home _____ Business _____ Cell _____

Relationship _____

The City is required to provide statistical information to the U.S. Department of Housing and Urban Development on those participating in our program. Please check each category below that applies. There may be a delay in processing the application if the statistical questions are not completed.

Male ___ Female ___

Age: under 30 years _____
31 to 45 years _____
46 to 60 years _____
61 to 75 years _____
over 75 years _____

Ethnicity: (select *only one*)

Hispanic or Latino _____
Not Hispanic or Latino _____

Race: (select any that apply)

American Indian/Alaskan Native ___
Asian ___
Black/African American ___
Native Hawaiian/Other Pacific Islander ___
White ___

Are you disabled based on the Hud Section 504 regulation found on the front page of this application?
(No proof of disability is necessary if you're being accepted based on age or income.)

Yes _____ No _____

On average, how many one-way trips per month do you believe you will use? (2 One-Way Trips = 1 Round Trip)

___ less than 2 per month ___ 2-8 ___ 9-16 ___ 17-24 ___ 25-34 ___ 35 or more

How did you find out about the program? _____

When is the best time to contact you? _____

**CITY OF ST. PETERS
TRANSPORTATION PROGRAM**

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name: _____

Date of Birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

City of St. Peters

Address: P.O. Box 9, St. Peters, MO 63376

3. The type and amount of information to be used or disclosed is participant information provided with my application for the City of St. Peters Transportation Program relating to my transportation needs.
4. This information may be disclosed to and used by the following individual or organization:

Carrco LLC dba Express Medical Transporters

Address: 2026 Trade Center Drive, East, St. Peters, MO 63376 for the purpose of: Transportation Services.

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Christine Cattoor. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: No longer a participant under the Transportation Program. If no expiration date, event, or condition is specified, this authorization will expire in six months.
6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Christine Cattoor.

Signature of transportation participant or legal representative:

_____ Date _____

If signed by legal representative, authority to act for transportation participant:

Signature of witness:
