

NAME:

ID #:



7101 WYOMING STREET, WESTMINSTER, CA 92683

TRANSPORTATION DEPARTMENT PHONE: (714) 702-1433 FAX: (714) 893-4819

JOSE MENDOZA j.mendoza@abrazarinc.com, ISRAEL ALVAREZ i.alvarez@abrazarinc.com

ABRAZAR SNEMT-NORTH INSTRUCTIONS & GUIDELINES - (714) 702-1433

Welcome to Abrazar (means to EMBRACE)! Your application for our Senior Non-emergency Medical Transportation (SNEMT) program will be reviewed and you can start requesting trips to and from your medical appointments **once you have received your ID#**. We look forward to assisting you with your medical transportation needs. Please communicate regularly with your coordinators to improve and enhance the program and service.

SCHEDULING APPOINTMENTS:

1. Always have your **ID#** ready when calling to schedule an appointment.
2. Rides must be scheduled a **minimum of 5 business days in advance**. This **does not guarantee the trip will be available**.
3. Call to schedule your appointment as soon as possible.
4. Please call your coordinators with any changes to your profile (address, phone, emergency contact, schedule, medical condition, equipment used, etc.) or for any special requirements.
5. Abrazar is not currently at capacity. If we are, we are required to prioritize trips.
6. **Scheduling Tips: (1) Call 10 business days in advance. (2) Schedule appointment on Tuesday or Thursday (3) Schedule all trips between 10:00 am to 3:00 pm. We understand that it is not always possible to do this but the likelihood of a trip being available is very high when following these tips.**

PICK UP TIME – There is a 30-minute window for your pick up time.

1. Your scheduled pick up time **will always have a 30-minute window**.
2. Please schedule and discuss your pick up time accordingly with your coordinator.

MILEAGE LIMIT - The program has the following mileage restrictions:

1. 15 miles within Orange County and 10 miles outside of Orange County.

TRIP TYPE AND LIMIT - The program has the following trip type and limit policy:

1. All trips are **REQUIRED** to be medically related.
2. Verification of the type of appointment will be required for non-traditional medical addresses. Regular exercise or balance classes are not eligible unless an eligible doctor's note is provided.
3. 16 one-way trips are allowable per month. Exceptions authorized based on treatment.

CLIENT CANCELLATIONS AND NO SHOWS

1. Please cancel 24 hours in advance of your scheduled trip.
2. **No Shows:** All cancellations that are less than 2 hours before your scheduled trip are considered a No Show. Please call ahead of time to cancel your trip. All No Shows are tracked and after **3 No Shows service may be suspended or cancelled**.

TRIP FEE - The program has the following \$2.00 per trip fee policy:

1. Abrazar is required to collect a \$2.00 fee per trip. If you do not provide the \$2.00 fee for your trip, Abrazar is still required to pay the \$2.00 fee. This limits the amount of trips we can provide each year. We respectfully request that you assist in supporting the program and provide the \$2.00 fee for each trip taken.

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ADDITIONAL INSTRUCTIONS & CLIENT GUIDELINES:

1. Personal care attendants may ride free of charge.
2. Special accommodations available for medical equipment, personal care attendants, service dogs. Note requests on application.
3. If you have a problem with your transportation services please call the Transportation Coordinator to report the problem. We believe all matters should be able to be handles through respectful communication. If an issue remains unresolved, you can follow the grievance procedures outlined in the Abrazar SNEMT Client Service Form.
4. For questions or concerns regarding eligibility or exceptions for service, please call the Transportation Coordinator.
5. SNEMT Transportation will not be able to respond to emergency calls. **Please call 911 in the event of an emergency. We do not provide emergency transport to the emergency room.**
6. Please be ready to board promptly at your scheduled time and please follow driver instructions when boarding or exiting the vehicle.
7. Smoking is not permitted in the vehicle.
8. The transporting of alcohol is not permitted in the vehicle.
9. All transportation services must originate within the Orange County designated service area.
10. In order for the SNEMT Program to transport your wheelchair, it must be able to be secured, have brakes in working condition and weigh 600 pounds or less.
11. If you need to go to the same place each week on a routine basis, please inform the dispatcher and we can set up an ongoing schedule for your rides.

CLIENT TERMINATION OR SUSPENSION POLICY:

We do not take the suspension or termination of services lightly. Abrazar will try to communicate with you prior to suspension or termination of services. **Client termination or suspension from the program is at the sole discretion of Abrazar and may be necessary should any of the following situations occur:**

1. Abuse of the No-Show policy (3 no-shows within a 30-day period) or continued No-Shows.
2. Utilizing SNEMT for purposes other than medically related.
3. Not treating Abrazar's staff and others with dignity, respect, fairness, and friendliness.
4. Not respecting or damaging Abrazar's property.
5. Conducting yourself in a manner that is dangerous or disruptive to the coordinators or drivers.
6. Your condition does not allow for your safe transport. Examples include: (1) You refuses to use a mobility device that is needed (2) You require a gurney (3) Your equipment is not in operable conditions (w/c without brakes or footrests, walkers in poor condition, etc..).

Clients who do not follow the above responsibilities may be immediately suspended or completely lose the privilege of the SNEMT service. Clients will be notified verbally and by mail if service has been suspended or terminated. If you disagree with the suspension or termination of service, you may follow the procedures in the Abrazar SNEMT Client Service Form.



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LYDIA ORTEGA l.ortega@abrazarinc.com, CAROL SALAZAR c.salazar@abrazarinc.com

ABRAZAR SNEMT PROGRAM APPLICATION

PLEASE SIGN AND DATE ALL FORMS PRIOR TO SUBMITTING. INCOMPLETE APPLICATIONS WILL BE RETURNED.

Last Name: _____ First Name: _____ Date: _____

Date of Birth: _____ Age (60): _____ Male: _____ Female: _____

Address: _____ Apartment/Unit #: _____

City: _____ Zip Code: _____

Home Phone: () _____ Cell (2nd Phone #): () _____

- 1. Have you ever applied for OCTA ACCESS? Yes No
 If yes, were you issued an ID #, if Yes, please list? _____ Yes No
 If yes, are you able to utilize **OCTA ACCESS**? Yes No

- 2. Do you have any physical or functional limitations? Yes No
 If yes, please describe: _____

- 3. Do you require a mobility device or special equipment for transport?
 Please check all that apply: Yes No
 Cane _____ Walker _____ Wheelchair _____ Scooter _____ Oxygen _____ Other _____
 If yes, are you able to enter/exit the vehicle without your mobility device?
 _____ Yes No

Are you able to transfer from a wheelchair to seat with/without assistance?
 _____ Yes No

- 4. Will a personal care attendant or assistant be traveling with you? Yes No

- 5. Do you require door-to-door assistance? Yes No
 If yes, please describe reasons why: _____

6. Please list your primary doctor(s) Name: _____
 Doctor Phone: (____) _____ Note: _____
7. How often do you anticipate needing to use the transportation service?
 Daily _____ Weekly _____ Monthly _____ Other (note) _____
8. EMERGENCY CONTACT (1): _____ RELATIONSHIP: _____
 PHONE: (____) _____
- EMERGENCY CONTACT (2): _____ RELATIONSHIP: _____
 PHONE: (____) _____
9. How do you get to your medical appointments now? _____

10. Do you own a vehicle and are you able to drive? _____ Yes No

The following information is gathered for statistical data only and does not affect your eligibility:

How did you hear about the program? _____

Ethnic background: Asian Black Hispanic White Native American
 Other _____

Annual Income per individual (MANDATORY): _____

Financial Hardship Waiver Requested

My signature verifies all information in this application to be true.

Applicant signature

Date

PROGRAM USE ONLY

- Referrals to alternative transportation provided: _____
- Exceptions (temporary, unrestrictive etc.): _____
- Reason referred to OoA I&A: _____
- Need for follow-up contact: _____
- Annual Income: At or below 150% FPG Above 150%FPG Financial Hardship Waiver



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ABRAZAR SNEMT PROGRAM WAIVER
PLEASE SIGN AND DATE ALL FORMS PRIOR TO SUBMITTING. INCOMPLETE APPLICATIONS WILL BE RETURNED.

I hereby acknowledge that the transportation is a service provided by ABRAZAR and funded by the County of Orange, Office on Aging. I hereby waive the right to make any claims against ABRAZAR and the County of Orange, Office on Aging or their officials, employees and volunteers, for any injuries, damages, charges or expenses, including attorney’s fees, which might be sustained as a result of my participation in the SNEMT Program. I also acknowledge that ABRAZAR reserves the right to refuse transportation service.

PLEASE PRINT:

Name: _____ Date: _____

Client signature: _____

Caregiver signature (if applicable): _____

Please return these forms to the Transportation Coordinator (s), Jose Mendoza Israel Alvarez, Lydia Ortega, or Carol Salazar. You can mail or drop off your application in the enclosed envelope. You can also fax them in or email a scanned copy to a.snemt@abrazarinc.com. Services can be scheduled after all forms have been **submitted and approved and you have received your ID#.**

Confirmation of approval will be made by phone within five business days after receipt of completed forms and you will be provided with your ID#.