NORTH

7101 WYOMING STREET, WESTMINSTER, CA 92683
TRANSPORTATION DEPARTMENT PHONE: (714) 702-1433 FAX: (714) 893-4819
LYDIA ORTEGA lydia.ortega@abrazarinc.com, JOSE MENDOZA j.mendoza@abrazarinc.com or
KHANH NGUYEN K.NGUYEN@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: _____

Address: _____ Suite #: ____ City: _____ Zip Code: _____

Doctor Phone: (___) _____ Note: _____

7. How often do you anticipate needing to use the transportation service?
Daily _____ Weekly ____ Monthly ___ Other (note) _____

8. Emergency Contact Name: _____

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

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

_____

Applicant signature **Date**

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

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:** _____

Address: _____

City: _____ **Zip Code:** _____

Phone: (____) _____

Client signature: _____

Caregiver signature (*if applicable*): _____

EMERGENCY CONTACT (1): _____**RELATIONSHIP:** _____**PHONE: (____)** _____

EMERGENCY CONTACT (2): _____**RELATIONSHIP:** _____**PHONE: (____)** _____

Please return this form to the Transportation Coordinator (s), Lydia Ortega, Jose Mendoza or Khanh Nguyen. **You can mail, fax, or drop off your application in the enclosed envelope**. Services can be scheduled after all forms have been submitted and approved. Confirmation of approval will be mailed within five business days after receipt of completed forms.