The Community Rides

Non-Emergency Medical Transportation

Please contact TripLink for assistance in completing this form.

General Information

The Alliance for Community Transportation (ACT) is the Regional Coordination Council for Community Transportation in Southeast NH. For more information about ACT, including a complete list of towns served, please visit www.communityrides.org.

ACT works with a coordinated network of transportation providers to serve as the "provider of last resort" for curb-to-curb non-emergency medical transportation within the ACT region. You are encouraged to contact other services that you might be eligible for, before requesting a ride through our Community Rides program. Rides are provided at no charge, but riders are limited to **10 one-way trips per month**. There is no guarantee that your request will be fulfilled.

Because funding is limited and trips are not guaranteed, we encourage you to research multiple transportation options to meet your needs.

Ride requests are made by contacting TripLink at **(603) 834-6010, 1-855-SENH-BUS** (736-4287) or **triplink@communityrides.org**. Your ride request is posted to a confidential "Trip Board". ACT's network of providers will then have the opportunity to view the trip requests and determine if they are able to fulfill that request. Riders will be notified within 2 days of their trip if their request has been selected.

The purpose of this application is to allow you to provide ACT with the information necessary to determine if you are eligible for this service, as well as the contact information we will need to reach you. Submit your completed application to **triplink@communityrides.org**.

Who Qualifies

The Community Rides program provides non-emergency medical transportation to residents of the ACT region who are 60+ years old or who have a disability. This application will help us to determine if your disability qualifies you for this service.

Transportation is available from your residence to medical care located within the 38 towns served by ACT.

The Community Rides program cannot provide transportation for COAST's ADA clients for ADA-eligible trips. Transportation cannot be provided for Medicaid clients for Medicaid-eligible trips.

Other Formats

If you need this document in large print or to be read aloud for you, please ask TripLink for assistance.

Instructions

1. Fully complete Part A, pages 3-6. In this part, you will describe your conditions or present qualifying evidence of a disability. You may have another person assist you in completing this application but please make sure that person completes the information on the bottom of page 6. **The person completing Part A cannot complete Part B.**

2. If you are basing your eligibility on options A - E listed below, please include the necessary documents with your application. If you are applying based on option F, please, sign and date page 7 and take or send the entire application (Parts A and B) to one of the health care professionals listed on page 10. That professional must complete Part B (pages 8-11).

3. If applicable, return both parts of the completed application to TripLink. Please remember that we cannot process an incomplete application. Email the completed application to triplink@communityrides.org or mail it to ACT, 42 Sumner Drive, Dover, NH 03820.

Evaluation and Notification

YOU WILL BE DEEMED ELIGIBLE FOR THIS SERVICE IF YOU ARE IN AT LEAST 1 OF THE CATEGORIES LISTED BELOW:

A. You are 60 or older. Please provide proof of your age.

B. You have been found at least 70% disabled by the Veterans' Administration. Please attach a letter signed by a Veteran's Service Officer that specifies your disability rating.

C. You have a Medicare card. Please bring your Medicare card to ACT or mail a photocopy.

   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 fill out Part B.

D. You have been found disabled by the Social Security Administration. Please attach proof of receipt of SSI or SSDI benefits, such as a bank statement. You may attach an award letter, but it must be dated within 1 year 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.

E. You 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 you are currently in the intake process during which this determination will be made. You must provide documentation of this determination.

F. None of the above applies to me, but I have a qualifying disability. *{This necessitates further documentation by the applicant in Part B}*

Client Application - Part A

(To be completed by Applicant)

I. Personal and emergency notification information
Please Print

Last Name ____________________ First __________________ Initial__

Address ___________________________ City _________________ State ___ Zip ___________

Name of apartment or neighborhood (if applicable)____

Date of Birth ____ / ____/ _______ Gender ☐ Male ☐ Female

Home Phone ____________________ Cell Phone ___________________________

Email ________________________________

Are you a Medicaid client? Yes No

Have you ever served in the military? Yes No

Mailing Address, if different from above

Address ___________________________ City _________________ State ___ Zip ___________

Emergency notification contact

Name _________________________ Relationship ___________________

Home Phone ____________________ Cell Phone ___________________________

Email ________________________________

Please list the most frequent medical centers to which you need to travel.

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

Basis for Eligibility

I am at least 60 years old

I have been determined to be disabled by the SSI

I have a 70% disability from the VA

I have a SMI or SMPI

I have a Medicare Card

I have a qualifying disability, described in Part B

PART A – Continued

II. Physical or mental impairment information

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

Example:

Condition*: Paraplegic - Confined to wheelchair* ____________________

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

Condition: ____

Effect: ____

Condition: ____

Effect: ____

2. Is your Condition temporary?

☐ No ☐ Yes, expected end date: ______________________
☐ I don't know

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

Check all that apply:

☐ None ☐ Walker ☐ Manual Wheelchair
☐ Crutches ☐ Prosthesis ☐ Powered Chair/Scooter
☐ Cane/White Cane ☐ Service Animal ☐ Other ______________________

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

Length ____________in Width ____________in

Weight ____________lbs – Combined person and device

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

PART A – Continued

5. 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.

6. Will you need to travel with a PCA?
   ☐ Always ☐ Sometimes ☐ Never

A Personal Care Attendant (PCA) can be any person, including an older child, whom you need to help you get to and from bus stops, get on or off the bus, negotiate the route or assist you at your destination. No special training is needed to be a PCA. ACT does not supply PCAs.

RELEASE OF INFORMATION & APPLICANT SIGNATURE

I understand that the purpose of this application is to determine my eligibility to use the ACT Community Rides Non-Emergency Medical Transportation service and agree to release the information herein to ACT. I understand that ACT 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 ACT may contact the health care professional who has completed Part B 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 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 ____

This signature page must be submitted with your application

AUTHORIZATION FOR
RELEASE OF MEDICAL INFORMATION

TO BE COMPLETED BY APPLICANT

Dear Health Care Professional:

I have applied to the Alliance for Community Transportation (ACT) to be certified as eligible for their Non-Emergency Medical Transportation Service. Part of this application process requires a health care professional (see list on Page 10) to review the information I have provided. I hereby authorize you to provide this information by completing Part B of the application and to discuss it with COAST staff.

I have completed Part A of this application and have attached it to Part B.

Signature ____ Date ______________

Client Application - Part B

EVALUATION OF FUNCTIONAL ABILITY

TO BE COMPLETED BY A
HEALTH CARE PROFESSIONAL LISTED ON PAGE 10

<u>Cannot be completed by person assisting the applicant with Part A</u>

The Community Rides NEMT curb-to-curb transportation service is for people who have a physical or mental impairment (Condition) that precludes them from riding in vehicles that do not have any accessibility features, such as your typical car, truck, or SUV. The Community Rides clients are generally picked up outside their homes at or near the requested time and taken directly 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.

Instructions
The applicant (or their representative) has completed Part A (which must be attached) and has requested that you complete Part B. If you are unsure how to answer particular questions, we suggest that you speak with the applicant or with TripLink. This will help expedite the application process.

Please return the entire application as soon as it is completed. The application must be filled out completely or it will not be processed. A representative may contact you to discuss the information you provided.

If you have any questions about this form, you may contact
TripLink at (603) 834-6010 or triplink@communityrides.org

PART B – Continued

Expected Duration of Condition

- ☐ Temporary: End date ________ / ____ / ______________
- ☐ Long-term: Condition has potential for improvement or long periods of remission.
- ☐ Permanent: Condition will not improve.

Please answer the following questions.

A. Is the information about the applicant's Condition and travel capabilities provided in section II on pages 4 and 5 complete and accurate?

☐ Yes ☐ No

Comment: ____

____

B. Is there any other reason that the applicant cannot independently and safely enter, exit, and ride in an vehicle that doesn't have any accessibility features?

☐ Yes ☐ No

Comment: ____

____

PART B – Continued

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

Part B must be completed by one of the following health care professionals who is familiar with the Applicant's condition:

Must be a Licensed or Certified:

Physician	Physician Assistant
Licensed Social Worker	Psychologist
Respiratory Therapist	Physical Therapist
Psychiatrist	Audiologist
Nurse Practitioner	Optometrist /Ophthalmologist
Registered Nurse	

I hereby certify that the above information is true and accurate to the best of my knowledge.

Signature ______________________________ Date __________________________

Print Name ____

Professional Title ____

Address ____

City ____State ________ Zip Code _________________

Telephone Number ____

Fax Number ____