VENTURA COUNTY AREA AGENCY ON AGING ELDERHELP PROGRAM (EHP)

TRANSPORTATION REFERRAL FORM FY 2018-2019

Please email this form to: Elder.Help@ventura.org or call with the info: 805-477-7300

REFERRING AGENCY INFO	
Requesting Agency:	Today's Date:
Requestor:	Phone Number:
Client informed of this referral? ☐ Yes ☐ No	Email Address:

BUS TICKETS *A limited number of tickets are available for people with disabilities under age 60. Everyone must provide a copy of their ADA Card prior to tickets being mailed.*

Fixed Route (Regular Bus) Tickets for:	**Dial-A-Ride (Paratransit Bus) Tickets for:**
☐ **Zone 1**: VCTC: Fillmore, Santa Paula, Ojai, Port Hueneme, Oxnard, Ventura, Simi Valley, and Thousand Oaks buses ☐ **Zone 2**: VCTC Intercounty: (Ventura, Santa Barbara, and Los Angeles Counties)	☐ GO Access (Ojai/Port Hueneme/ Oxnard/Ventura) ☐ Simi Valley Transit ☐ Valley Express (Santa Paula/Fillmore/Piru) ☐ Camarillo Area Transit ☐ Thousand Oaks Transit ☐ East County

EHP MEDI-RIDE TRANSPORTATION REQUESTS *Rides are limited to 2 per month; however, caps can be implemented at any time based on funding. Complementary and Alternative Medicine are not approved for EHP Medi-Rides. 5 business days' notice is REQUIRED to process ride requests.*

Type of vehicle needed ***(choose one)***:

☐ Car ☐ Wheelchair Van ☐ Gurney Van ☐ Uber

➔ Any Comments/Concerns for the driver (i.e. firearms, large dogs, hoarding, etc.):

➔ **Justification why service is needed & client cannot take Dial-A-Ride to the appointment *(ex. requires door-through-door gurney transport)*:**

1. Appointment(s) with specific Doctor/Hospital Name: Type of Medical Practice (ex. Primary Care, Cardiology, Geriatric):	
Date(s)/Time(s) of appointment(s):	
Address:	City:
Roundtrip Appointment(s)? ☐ Yes ☐ No	Appointment(s) Length?
Is an escort going? ☐ Yes ☐ No *If yes, name and phone of escort:*	

2. Appointment(s) with specific Doctor/Hospital Name: Type of Medical Practice (ex. Primary Care, Cardiology, Geriatric):	
Date(s)/Time(s) of appointment(s):	
Address:	City:
Roundtrip Appointment(s)? ☐ Yes ☐ No	Appointment(s) Length?
Is an escort going? ☐ Yes ☐ No *If yes, name and phone of escort:*	

REQUIRED INFO ABOUT THE CLIENT

Client Name: Birth Date:

Does client have Medi-Cal? ☐ Yes ☐ No Primary Language:

Client Phone: Phone Type: ☐ Smart ☐ Basic Mobile ☐ Landline

Does client live alone?	☐ Yes ☐ No	Where does client reside?
Number of Persons in Household:		☐ Home ☐ Hospital ☐ Rehabilitation ☐ Board & Care
Veteran Status:	☐ Yes ☐ No	☐ Assisted Living ☐ Skilled Nursing Facility

Street Address *(Transportation Provided From)*:

City: ZIP:

Caregiver Alternate Phone:

Marital Status: ☐ Divorced ☐ Domestic Partner ☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Decline to State

Applicant's Income Level (approximate):

1-Person Household:
☐ At or below Federal Poverty Level *($12,140/year or less)*
☐ Above Federal Poverty Level *($12,141/year or more)*
☐ Decline to State

2-Person Household:
☐ At or below Federal Poverty Level *($16,460/year or less)*
☐ Above Federal Poverty Level *($16,461/year or more)*
☐ Decline to State

RACE – Please Choose (✔) One:

☐ American Indian or Alaska Native
☐ Asian Indian
☐ Black or African American
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Guamanian
☐ Hawaiian
☐ Japanese
☐ Korean
☐ Laotian
☐ Multiple Race
☐ Other Asian
☐ Other Pacific Islander
☐ OTHER RACE – Includes Hispanic /Latino
☐ Samoan
☐ Vietnamese
☐ White
☐ Decline to State

Ethnicity:

☐ Not Hispanic/ Latino
☐ Hispanic/ Latino

The Gay Bisexual and Transgender Disparities Reduction Act of 2016 (AB 959)

The State of CA requires that we ask you some demographic questions followed by three questions under the new CA State AB 959 Law, the Gay, Bisexual and Transgender Disparities Reduction Act of 2016. VCAAA values your privacy and you have the option to decline to state.

What was your sex at birth? ☐ Female ☐ Male ☐ Decline to State

What is your Gender? ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer/Gender Non-binary ☐ Decline to State ☐ Not listed, please specify: _____

How do you describe your sexual orientation or sexual identity? ☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Decline to State ☐ Not listed, please specify: _____

Daily Activities – Help Is Needed:	Independent, Needs No Help	Verbal Cueing Required	Standby Assist Required	Hands On Assist Required	Dependent On Others For Task
Eating/Feeding Self	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐
Transferring	☐	☐	☐	☐	☐
Bathing	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐
Grooming	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐
Preparing Meals	☐	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	☐
Managing Medicines	☐	☐	☐	☐	☐
Managing Money	☐	☐	☐	☐	☐
Using the Telephone	☐	☐	☐	☐	☐
Doing Heavy Housework	☐	☐	☐	☐	☐
Doing Light Housework	☐	☐	☐	☐	☐
Using Avail Transportation	☐	☐	☐	☐	☐

FOR VCAAA USE ONLY

Date EHP Referral Received: Approved: ☐ Yes ☐ No

Date Requesting Agency Contacted: Comments:

Approved Service: ☐ Fixed Route Tickets ☐ Dial-A-Ride Tickets ☐ Medi-Ride Transport

Units approved: Service Date(s) Approved:

Price per unit: Vendor selected: