Final: Version 1.5

☐wait list   Date: _____

Multnomah County
Aging and Disability Services Division
Fare Assistance Assessment Tool

Date: _____   District Center: ☐N/NE ☐SE ☐Mid County ☐East County ☐West side
☐New client assessment ☐Annual re-assessment *(☐ if no changes go on to page 2)* ☐UCR completed


Client Name: (first)_____ (last)_____

Address: _____Phone number: _____

DOB: _____ Prime number: _____

☐Served in US military   Requesting what type of fare?: ☐Adult ☐Honored Citizen ☐Lift

☐Multnomah Co. resident <u>AND</u> ☐resides in DC catchment area <u>OR</u> ☐waiver approved to serve client

---

Client **must** be provided with a Transportation Program Letter (on DC letterhead). ☐Date provided_____
☐in person ☐mailed ☐by phone and followed up with letter mailed   By (initials): _____
☐ letter translated to the languages spoken by client ☐No translation needed.

Part A: Transportation Resources
1. Has car/access to car/is able to receive rides from family/friends ☐Regularly ☐Occasionally ☐Never
2. Lives with family or has family who could provide resource(s) for transportation/fare ☐YES ☐NO
3. Receives transportation assistance from another agency or community resource? ☐YES ☐NO
    - If "YES", is this an ongoing/consistent resource? ☐YES ☐NO Comment: _____

DECISION: Are client's transportation needs adequately met? ☐NO OR ☐YES

STOP—no need for fare

Part B: INCOME VERIFICATION
Number in household supported by income listed below: ____

MONTHLY INCOME:	SELF	SPOUSE
Social Security Benefits	$_____	$_____
Supplemental Security Income (SSI)	$_____	$_____
Other Income	$_____	$_____
TOTAL MONTHLY INCOME	$_____	$_____

Under 150% FPL? ☐ Yes ☐ No=continue to adjusted income below

Total income (if above 150% FPL)   _____
Subtract expenses:
- Medical expenses (premiums, co-pays, out of pocket costs) _____
- Rent/ housing cost (mortgage, insurance and property taxes) _____
- Utilities   _____

                    Total Deductions: _____
Total adjusted monthly income: _____
Meets 150% FPL ☐ Yes→go on to next section ☐ **No**→*STOP client use own resources for transportation needs*

Client statement: *The income and monthly expenses I have reported here are true and accurate to the best of my knowledge. I understand that misrepresentation of my income and monthly expenses may be grounds for disqualification from this fare assistance program.*

☐read to client by _____ and they understood or ☐Client initials: _____

Client name: _____

Part C: Transportation Needs/Risk

Please use this as a guide to have an in depth conversation with the person about their trips and their unmet transportation needs. Use probing questions to ensure that information is accurate and complete.	**# of 1 way trips/month unmet need** *If none, mark "0"*	**Comment/explanation:**
Medical/health trips, getting Rx's *(note: anything over 2 visits/4 one-way trips, you may request verification.)*		
Grocery shopping	(8 max)	
Congregate meals/Senior Ctr recreational	(16 max)	
Personal business (i.e. church, library, etc)	(8max)	
Employment/Volunteer *(note: you may request verification of work/volunteer schedule/pay stub etc.)*		
TOTAL unmet 1 way trips/month =	_____ Assessment score *Note: 10 or less does not qualify for fare assistance. Offer other resources, referral to Ride Connection, Options Counseling, etc*	

Counseling and education offered to client about combining rides, stores in their neighborhood, etc to help with their transportation plan. ❑yes ❑Client refused

❑ADRC print out of transportation options provided   ❑ Ride Connection program brochure provided
❑Other printed materials/resources provided

Comments: _____

_____

_____

❑**Annual Review:**   Information reviewed and discussed with client by: _____ Date: _____
      ❑Transportation Program letter ❑given ❑mailed ❑by phone and followed up with letter mailed
      ❑no change to income ❑no change in need ❑no change to risk

---

Assessment score	Level of Fare Assistance
44+	Bus Pass or Tri Met Lift Pass
31-43	20 bus tickets or lift punch pass
20-30	10 tickets
11-19	5 tickets
10 or below	Need not great enough to qualify. Refer to other services (Ride Connection, OC, etc)

❑*Client was informed that if their transportation need decreases or if they do not need fare assistance for a period of time they should contact the Transportation Coordinator so that scarce resources can be given to someone else. Any unused fare should be returned to the District Senior Center.*

Assessment Completed by: _____ Title: _____ Date: _____