[ ]  Approved Service type approved:

[ ]  Approved – Underserved Effective date:

[ ]  Denied

[ ]  Waitlist

**Transportation Assistance Assessment Tool**

**Date:** **Your Agency:**

[ ] New Assessment [ ] Entered in UCR [ ] Change/Edit Information [ ] Annual Reassessment

|  |  |  |
| --- | --- | --- |
| Name:(First)       | (Last)       | [ ]  Served in US military |
| Address:       | Phone#:       |  |
| City:       | County:       | ZIP:       |
| DOB:       | Prime#:       |  |
| Eligibility Benefit (enter descriptor codes):      ***(search Oregon Access to obtain Prime# and identify benefits i.e. Medicaid, OHP, CCO, Title XIX Services)*** |

Transportation Program Letter (on DC letterhead). Date provided

[ ]  in person [ ]  mailed [ ]  letter translated Language       [ ]  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. Receives transportation assistance from another agency or community resource?
* If ‘Yes’ is this an ongoing/consistent resource? [ ]  YES [ ]  NO
* Comment:

DECISION: Are client’s transportation needs adequately met? [ ]  NO - *Continue to Part B*

[ ]  YES - ***STOP*** *(no need for fare)*

**Part B: Income Verification**

Number in household supported by income listed below:

**MONTHLY INCOME**

|  |  |
| --- | --- |
| Social Security Benefits |       |
| Supplemental Security Income |       |
| Other Income |       |
| **Total** |  |

**Under 150% FPL?** **[ ]  YES -** *Continue to Part C***[ ] 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:** |  |

Under 150% FPL [ ] **YES** – *Continue to Page 2*  **[ ] NO** - **STOP (***Does not meet eligibility criteria)*

Client name:

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        | **(OR)** [ ] Client Acknowledge |

 **Part C: Transportation Needs/Risk**

|  |  |  |
| --- | --- | --- |
|  | **Total unmet one-way trips/month** | **Comment/explanation:**  |
| Medical/Pharmacy  |     |       |
| Grocery Shopping  |     |       |
| Congregate Meals/Community Center Activities |     |       |
| Personal business (i.e. church, library)  |     |       |
| Volunteer activities  |     |       |
| Employment |     |       |
| **Total unmet one-way trips/month**  |      **Assessed score**  |

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

[ ]  Link to ADRC of Oregon Resource Database **(OR)** Transportation resources printed from ADRC website and provided to applicant

[ ]  Ride Connection program brochure provided

[ ]  Referred for Multnomah County Premium Rides

Comments:

**[ ]  Annual Reassessment:** [ ]  No change to income [ ]  No change in need [ ]  No change to risk

|  |  |
| --- | --- |
| **Assessment score** | **Level of Fare Assistance** |
| 50+ | Bus Pass or Tri Met Lift Pass |
| 31-49 | 20 bus tickets or lift punch card |
| 30 or less | Actual need, not to exceed 10 tickets |

[ ]  *Client was informed that if their transportation needs decrease, or if they do not need fare assistance for a period of time, they should contact the Transportation Coordinator. Any unused fare should be returned to this Agency.*

|  |  |  |
| --- | --- | --- |
| Assessment Completed by:        | Title:       | Date:      |