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: |