Rider application for
West Marin TRIPTrans

Sponsored by Marin Transit
& funded by the Metropolitan Transportation Commission's New Freedom Program. Administered by WEST MARIN SENIOR SERVICES

IMPORTANT INFORMATION FOR APPLICANTS

This packet includes an application form you need to complete to apply to be a participant in the West Marin TRIPtrans program.

To apply for eligibility you must fully complete the attached application form. We will review your application, we may need more information. If that is the case, we will contact you by phone.

Your application will be processed within 21 days after it has been received. You will receive notice of your eligibility for the TRIPtrans program by mail. If you are eligible, we will begin working with you to help you identify your volunteer driver and provide you with a packet of information for you and your driver about how the program works.

INSTRUCTIONS FOR APPLICANTS

1. Please **PRINT full responses to all of the questions** on the application form. Your detailed responses and explanations will help us to determine if you are qualified for TRIPtrans. Be sure to **respond to ALL questions or your application will be considered incomplete**. Incomplete applications will be returned.

2. You are not required to attach additional pages or information. However, you may want to send other documents that you think will help us understand your limitations. **All information that you supply will be kept strictly confidential.**

3. **You must provide a SIGNATURE, on the Applicant Certification form, to complete the application**

4. **Return the completed application to:**
   West Marin Senior Services
   TRIPtrans
   P.O. Box 791
   Point Reyes Station, CA 94956

For help with the application process or to check on the status of your application call 415-663-8148. Thank you!

Please Print

Date:_____

Name *(first, middle, last):*

_____

Name of Housing Complex (if applicable)_____

Street:_____ Apt. #: _____

City: _____ Zip: _____

Mailing Address *(if different from home):*

_____ Apt. #: _____

City: _____ Zip: _____

Daytime Phone: (_____) _____ **TDD/TTY:** (____) _____

Evening Phone: (_____) _____ Cell Phone: (_____) _____

Birth Date: ____/____/____ ☐ Female ☐ Male

Primary Language *(please check):* ☐ English ☐ Other *(specify)* _____

If you need any future written information provided to you in an accessible format, please check which format you prefer*:*

☐ Diskette/CDR ☐ Audio tape ☐ Braille ☐ Large Print
☐ Other _____

In case of emergency, whom should we contact?

Name: _____

Relationship: _____ Email: _____

Day Phone: (____) _____ Eve. Phone: (____) _____

(Optional) I am also enrolled in one or more of the following programs:

Medicare ☐ Medi-Cal ☐

Please Print

Tell Us About Your Disability / Health Related Condition

Please answer the following questions in detail – your specific answers to the questions will help us in determining your eligibility.

1. Briefly explain below **HOW** your condition prevents you from using other forms of transportation such as those listed above either some of the time or all of the time:

_____

_____

_____

_____

_____

_____

Tell Us About Your Capabilities and Usual Activities

4. Do you regularly use any of the following mobility aids or specialized equipment? *(Check all that apply):*

☐ Cane	☐ Power Wheelchair	☐ Communication Devices
☐ White Cane	☐ Service Animal	☐ Walker
☐ Power Scooter	☐ Crutches	☐ Manual Wheelchair
☐ Leg Braces	☐ Portable Oxygen Tank	

☐ Other Aid _____

5. Please check the box that best describes your current living situation:
   - ☐ Assisted Living Facility
   - ☐ I receive assistance from someone that comes to my home to help with daily living activities. IHSS worker? Yes___ No___
   - ☐ I live with family members or others who help me.
   - ☐ Is your family member your IHSS worker? Yes___ No ___
   - ☐ I live independently (without the assistance of another person)
   - ☐ Low income senior housing

Please Print

Tell Us about Your Travel Experiences

6. How many trips do you take for medical purposes each month? *(Check the box that applies):*
   ☐ 0- 4 trips per month
   ☐ 5-9
   ☐ 10 or more

7. What are the reasons for medical travel?
   _____
   _____

8. Where are the doctors or clinics located? (Name the city or towns)
   _____
   _____

9. Please add any other information that you would like us to know about your abilities and how you think the Volunteer Driver Program will meet your needs.
   _____
   _____
   _____
   _____

Did someone help you in filling out this form? ☐ Yes ☐ No

If yes, Name: _____ Phone: (____) _____

Relationship: _____

Have you answered all the questions and provided explanations where required?

INCOMPLETE APPLICATIONS WILL BE RETURNED.

Applicant Certification

I request eligibility certification and participation in the TRIPtrans Volunteer Driver Program. I have reviewed my application and certify that it is accurate and true. I understand that the information I am providing will be treated as confidential, will only be used to determine my initial and continuing eligibility for the program, and will be retained as a permanent part of my service file.

All of the information which I have provided is true and accurate to the best of my knowledge. I authorize representataives of TRIPtrans to contact persons whom I have named, or to make other inquiries as necessary, to verify the information which I have provided.

I understand that it is the policy of TRIPtrans to pursue any alleged or suspected instance of fraud. A "fraudulent claim" is committed when a false representation of a present or past fact is made by a TRIPtrans customer, members of their family, or unrelated person such as their caregiver or volunteer driver, which results in the release of funds.

I agree to abide by all the TRIPtrans policies, as communicated to in the notification of service that will be sent to me, in the Rider's Handbook which I will receive, or as communicated to me in any other way, and I acknowledge that failure to abide by Policies may result in the termination of TRIPtrans services.

I acknowledge that being driven by others is an inherently dangerous activity and that my participation in this program could involve some danger to my person, to my property, or the person or property of others. In consideration of my participation in the TRIPtrans however, I hereby forever release from liability and agree to indemnify and hold harmless Marin Senior Coordinating Council, West Marin Senior Services and any and all organizations, agencies or individuals who provide funding to or otherwise support the program, from any and all claims, losses, and liabilities arising out of or in any way connected with my participation in the TRIPtrans.

I understand that it may be necessary to contact a professional familiar with my functional abilities to determine my eligibility for this program.

Sign here:

Applicant's signature _____ Date _____

CONFIDENTIAL

West Marin TRIPtrans
West Marin Senior Services Volunteer Driver Program
P.O. Box 791
Point Reyes Station, CA 94956
415-663-8148

VOLUNTEER DRIVER INFORMATION

Please have your volunteer fill this out and return it to West Marin Senior Services.
This information will be used for emergency contact only.

Date: _____

Last Name:_____ First_____ MI____

Address:_____ Apt/Space #__

City:_____ State:_____ Zip:_____

Home phone:_____ Work Phone:_____

Cell phone:_____

Email address:_____ AGE:_____ SS #_____/___/_____

DO YOU HAVE CURRENT VEHICLE INSURANCE? YES___NO___

DO YOU HAVE A VALID AND CURRENT DRIVER'S LICENSE? YES___N0___

LICENSE #_____

WHAT IS YOUR RELATIONSHIP TO YOUR RIDER? (CHECK ONE)

FRIEND_____ NEIGHBOR_____ CAREGIVER_____ IHSS_____

CAREGIVER_____

OTHER (EXPLAIN):_____

PLEASE MAILTO THE ADDRESS ABOVE.
ATTENTION: CHLOE COOK, WEST MARIN TRIPTRANS COORDINATOR.

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Administered by
WEST MARIN SENIOR SERVICES