



## SPECIAL TRANSPORTATION SERVICES PROGRAMS APPLICATION

OmniTrans offers a variety of free or reduced-cost transportation programs for **seniors (age 62 plus) and individuals with disabilities** who live in OmniTrans' service area. The information obtained in this application will be used to determine eligibility for participation in these programs. All information that you provide will be kept strictly confidential and will not be provided to any other person or agency without prior written approval of the applicant.

Please check the box next to the program(s) you would like to participate in.

- Travel Training Program:** provides free one-on-one training on how to use the OmniTrans bus system. A travel trainer will show you everything you need to know about riding OmniTrans, including how to plan your trip, pay fare, how to safely ride the bus and so much more.
- Volunteer Driver Program:** provides participants unable to use public transportation a mileage reimbursement of \$0.40/mile to give to friends, neighbors or caregivers who help with rides to medical appointments, the grocery store, family visits, etc. Please note an active bank account is necessary to participate in this program.
- Lyft Program:** provides an \$80 code at a reduced cost of only \$40 to participants for their use towards rides on app based service Lyft. *Participants in this program must have a smart phone and be able to download and use the Lyft app on their phone.*
- Taxi Program:** provides an \$80 credit through a reloadable taxi debit card at a reduced price of only \$40 to participants. *If applying for the Taxi program, include a color headshot (this does not need to be a professional or passport photo).*

On the following pages, please **PRINT** full responses to all of the questions on the application form. Your detailed responses and explanations will help us to determine your eligibility. A **SIGNATURE** on the Application Certification form must be provided to complete the application. *Incomplete applications will be returned to the applicant and will not be processed.*

Your complete application will be reviewed and processed within 14 days after it has been received. If additional information is required, we will contact you by telephone. You may be required to send other documents that will help us better understand your abilities. Additional documents required may include a health verification form completed by your health care provider. OmniTrans will notify you by mail of your eligibility. If you are accepted, a welcome packet will be mailed to you containing program(s) details and instructions.

**Mail your complete application to:**

OmniTrans Special Transportation Services  
1700 W. Fifth Street, San Bernardino, CA 92411

If you have questions about our programs or application call, (909) 379-7341

Date \_\_\_\_\_

Your Name (First and Last) \_\_\_\_\_

**Home Address**

Name of Housing Complex (if applicable) \_\_\_\_\_

Street \_\_\_\_\_ Apt/Space/Unit # \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

**Mailing Address** (if different from Home Address)

Street \_\_\_\_\_ Apt/Space/Unit # \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

Primary/preferred Phone (\_\_\_\_) \_\_\_\_\_ Other Phone (\_\_\_\_) \_\_\_\_\_

Email address \_\_\_\_\_

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  Female  Male  
MM DD YYYY

Primary Language  English  Other (specify) \_\_\_\_\_

**How did you hear about our program (s)?**

\_\_\_\_\_

**Who do you live with?**

- |  |  |
|--|--|
| <input type="checkbox"/> Live alone                | <input type="checkbox"/> With paid caregiver         |
| <input type="checkbox"/> With spouse               | <input type="checkbox"/> In skilled nursing facility |
| <input type="checkbox"/> With other family members | <input type="checkbox"/> In assisted living facility |
| <input type="checkbox"/> With friends              | <input type="checkbox"/> Other _____                 |

**In case of emergency, whom should we contact?**

Name \_\_\_\_\_

Relationship to you \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

**Are you a senior (age 62 plus)?**  Yes  No **Do you have a disability?**  Yes  No

**If yes, your health conditions are:**  Permanent  Temporary

**Are your health conditions verified by a doctor?**

Yes  No If yes, when were they verified? \_\_\_\_\_

Have you ever served in the military?  Yes  No

If yes, do you have a service-related disability?  Yes  No

If yes, what is your percentage of disability?  Less than 30%  30% or more

**Are you able to drive a vehicle owned by you?**  I don't own a vehicle  Yes  No

If yes, do you have any limitations or restrictions?

Explain:

**Are you registered with any other transportation services /ADA paratransit services (such as Access)?**  Yes  No

**Are you able to use public transportation (buses) or ADA paratransit services for individuals with disabilities (Access)?**

Yes  No  Public transportation (buses or Access) is not available where I live  
 I don't know

Briefly explain health-related conditions/limitations/disabilities that prevent you from using public transportation (buses) or ADA paratransit services such as Access either some or all of the time:

**Please indicate any mobility aids you regularly use:**

None  Cane  Walker  Wheelchair  Other \_\_\_\_\_

**How do you think our program(s) will help meet your transportation needs?**

**If applying for Volunteer Driver Program, have you identified a potential driver?**  Yes  No

**If yes, what is your relationship to the driver?**

Friend  Neighbor  Caregiver/IHSS worker  Relative

Do you have an In-Home Supportive Services (IHSS) caregiver?  Yes  No

If yes, are they approved to drive/provide trips for you?  Yes  No

Does a family member drive you to places you need to go to?  Yes  No

If yes, does this family member live with you?  Yes  No

**Please describe your transportation needs below:**

**Types of medical trips you presently make (examples: primary care physician, physical therapy, dentist, pharmacy, etc.), and how often you need to travel?**

**Other purposes and destinations you would like to travel to and how often (examples: work, banking, shopping, family visits, religious, etc.)?**

**The following information assists us with our funding resources:**

Your ethnicity:  Not Hispanic or Latino  Hispanic of Latino  Decline to state

Your race:

White  African American  Native American

Asian  Pacific Islander  Decline to state  Other \_\_\_\_\_

**OMNITRANS**  
**Special Transportation Services Programs**  
Application Certification and Hold Harmless Form

I have reviewed my application to participate in the programs provided by OmniTrans and certify that it is true and accurate to the best of my knowledge.

I understand that the information I am providing will be treated as confidential, will only be utilized to determine my initial and continuing eligibility for the programs, and will be retained as a permanent part of my file. I authorize representatives of OmniTrans to contact persons whom I have named or to make other inquiries as necessary to verify the information that I have provided.

I understand that it may be necessary to contact a professional familiar with my functional abilities to determine my eligibility for the programs. I also understand that the County of San Bernardino may be verifying information provided in this application (such as In-Home Supportive Services participation).

I understand that it is the policy of OmniTrans to pursue any alleged or suspected instances of fraud. A "fraudulent claim" is committed when a false representation of a present or past fact is made by an OmniTrans consumer, member of his/her 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 OmniTrans policies, as communicated to me, including policies in the guidelines, and I acknowledge that my failure to abide by any program policy may result in the termination of services.

I acknowledge that being driven by others is an inherently dangerous activity and that participation in these programs could involve some danger to my person or property, or the person or property of others. In consideration of my participation in the programs, I agree to indemnify and hold harmless OmniTrans, its officers, directors, agents, employees, and volunteers, as well as any and all organizations, agencies, or individuals who provide funding to or otherwise support the programs, from any and all claims, losses, and liabilities (including costs and attorneys fees) for damage to property or injury or death to myself or others arising out of or in any way connected with my participation in the programs.

**Applicant Name** \_\_\_\_\_ **Date** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Applicant or Applicant's Legal Representative or Guardian**

\_\_\_\_\_  
**Relationship to Participant**

\_\_\_\_\_  
**Signature of Interpreter or Witness  
(if Applicant is blind or unable to sign)**