To:

Date:

Re: **Interest in Senior Citizen Transportation Program**

Thank you for your interest in our transportation program. In order to process your application, we must have all necessary documents and signed paperwork. Please understand that your signature acts as consent for the JCC to provide you with services.

Please note your eligibility application is enclosed. When returning the application, please make sure that all documents listed below are included and all fields are completed on each form. Blank fields will delay processing of your application. Please make sure the following is included:

- O **Proof of Age** (Current State/Federal issued photo ID)
- O **Proof of Residency** (State issued ID(must match address on application); utility bill in your name)
- O **Signed DFTA consent - all initials, signatures & attestation** (2 pages)
- O **Signed Application**
- O Note from Doctor if Wheelchair Accessible Vehicle/Ambulette is needed

Please do not send originals.
Your application will be processed in the order that it is received. Please allow 6-8 weeks for processing.

Thank you!
JCCGCI Transportation Department
718-449-5000 ext. 1

JEWISH COMMUNITY COUNCIL OF GREATER CONEY ISLAND

3001 West 37th Street Brooklyn New York, 11224 · Ph: (718) 449-5000 x 1·
E-mail: seniortrips@jccgci.org

Referred By:

JCCGCI ID#

CLIENT ELIGIBILITY CERTIFICATION FORM

Check off Services of Interest
- ❒Homecare
- ❒Transportation
- ❒Case Assistance/Access
- ❒Friendly Visiting
- ❒Telephone Reassurance
- ❒Socialization Programs

Last Name:_____ **First Name**:_____ **Middle Initial**:___

Maiden Name:_____ **Gender:** ❒ Male ❒ Female

Address:_____ **Apt:** _____ **City:** _____ **State:** ____ **Zip:**_____

Telephone: (____)_____-_____ **Cell Phone:** (_____)_____-_____

CD / NYCCD	AD / COND / SD

Date of Birth (Month Day Year) ___/___/___

Place of Birth (Town/City Country) _____/_____

Social Security Number

Ethnicity
❒Asian ❒Black ❒Hispanic ❒White ❒Other

Marital Status
❒Single ❒Divorced ❒Married ❒Widowed

 # Living in Household

Housing
❒Rent ❒Homeless ❒Own ❒Other

Homebound
❒Yes ❒No

Do you use a…?
❒Cane ❒Walker ❒Wheel Chair ❒None

Medical Conditions/Need for Transportation

Visual Impairments
❒Macular Degeneration
❒Legally Blind ❒None
❒Other_____

Hearing Impairments
❒Use hearing aid ❒Deaf
❒Other_____ ❒None

Source of Income
❒Social Security ❒SSI ❒Pension ❒Job
❒Other ❒Holocaust Compensation

Primary Language

Do you have/receive…?
❒Medicaid ❒Food Stamps
❒Meals-on-Wheels ❒Medicare
❒Access-a-Ride
❒Services from another Agency
Please Specify which Agency:
_____
Please Specify which Services:

TOTAL Monthly Income – for individual only, not spouse
❒$0-$439 ❒$550-$599 ❒$750-$899 ❒$1000-$1099 ❒$1300-$1499
❒$440-$549 ❒$600-$749 ❒$900-$999 ❒$1100-$1299 ❒$1500 or More

Monthly Income – Individual, not incl Government Income / Pension
❒$0-$439 ❒$550-$599 ❒$750-$899 ❒$1000-$1099 ❒$1300-$1499
❒$440-$549 ❒$600-$749 ❒$900-$999 ❒$1100-$1299 ❒$1500 or More

U.S Veteran
❒Yes ❒No

Emergency Contacts

1) Name:_____ Address:_____ City:_____ State:____ Zip:_____
Tel:(____)_____-_____ Cell: (____)_____-_____ Relationship:_____ Email:_____

2) Name:_____ Address:_____ City:_____ State:____ Zip:_____
Tel:(____)_____-_____ Cell: (____)_____-_____ Relationship:_____ Email:_____

Additional Information Needed:

PLEASE INCLUDE A COPY OF STATE ISSUED ID SHOWING PROOF OF AGE AND ADDRESS

►**PLEASE SUBMIT A COPY OF STATE ID** or **DRIVER LICENSE** or DOCUMENT CONFIRMING AGE AND BROOKLYN RESIDENCE;
►PLEASE SUBMIT A COPY OF **MEDICAID/MEDICARE CARD**;
►FOR AMBULETTE PLEASE SUBMIT A LETTER FROM DOCTOR CONFIRMING NEED FOR WHEELCHAIR ACCESSIBLE VEHICLE;

Date of Emmigration to US
Month/Year ____/_____

Email Address

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE

Client's Signature: _____ Date: _____

Case Worker's Name: _____ Agency: _____ Telephone: _____

New York City Department for the Aging

Last Name: _____ **First Name:** _____

Address: _____ **Apt. Number:** _____

City: _____ **State:** _____

Zip: _____ **Home Phone:** _____

Program: Project Relief **Cell Phone:** _____

Consent to Collect Data

Date Consent Provided to Collect Data: _____

I consent to having personal information provided by me or my legal representative entered into the Client Data System maintained by the New York City Department for the Aging. I understand what information will be recorded, why this information is needed, and that there are laws and regulations protecting my personal health and identifying information.

I understand that this information is being collected to help in providing services, including services funded through the New York City Department for the Aging. It also helps identify other services that I may qualify for. I understand that this information is needed in order for some services to be provided.

I understand that signing this authorization is voluntary and can be revoked at any time. If I refuse to sign this authorization, the above named service provider will not be able to help by making referrals for me. Information can be given to me to follow-up on my own.

Client Initial: _____

Consent to Share Emergency Preparedness Information

Date of Emergency Preparedness Consent: _____

In the event of an emergency, I consent to the release of my information contained in the Emergency Preparedness Form and have received a copy of this form. I understand that my basic demographics and social history are a part of my Emergency Preparedness information.

I understand that my information will be shared only with persons authorized to respond in an emergency, such as government agencies, law enforcement, or those acting on their behalf.

Client Initial: _____

I consent to the collection and sharing of my information as initialed above. This authorization shall not expire unless revoked by me or my legal representative.

Signature of Individual or Legal Representative

Date

Individual's Name (Print)

Legal Representative's Name (Print)

☐ Power of Attorney (POA)
☐ Guardianship

Please describe the relationship between the legal representative and the client:

FOR OFFICE USE ONLY

ATTESTATION (*To be completed by the worker*)

I attest that informed consent, as indicated, was obtained from the above individual, who provided his/her signature above. All appropriate processes were followed, and consent was provided voluntarily.

Signature

Date

Worker's Name (Print)

Worker's Title (Print)