



## TripLink Common Application

TripLink provides an online Common Application for nonprofit transportation services in southeastern NH on behalf of COAST, Community Rides, Ready Rides, Rockingham Nutrition & Meals on Wheels, TASC, and the Community Action Partnership for Strafford County. This alternative application may be submitted in its place. To learn more about these services and their eligibility requirements before applying, visit <https://www.communityrides.org/form/rider-application> or call 603-834-6010.

When using the Common Application, please answer all the questions in the CONTACT INFORMATION and ADDITIONAL INFORMATION sections of the form. Questions that are only asked for certain services are at the end of the application. You only need to answer questions for services to which you are applying.

Please fill out this application and mail or fax it to the following location. A representative will follow up upon receipt of your completed application.

TripLink  
42 Sumner Drive  
Dover, NH 03820

Fax (toll-free): 855-975-2546

## SERVICES

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### **I am applying for the following services:**

(check all that apply)

- COAST ADA Paratransit
- COAST Portsmouth Senior Transportation
- COAST Route 7 On Demand
- Community Action Partnership of Strafford County Senior Transportation Program
- Community Rides
- Ready Rides
- Rockingham Nutrition & Meals on Wheels Senior Shuttle
- Transportation Assistance for Seacoast Citizens (TASC)

## CONTACT INFORMATION

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**First Name:** \_\_\_\_\_ **MI:** \_\_\_\_ **Last Name:** \_\_\_\_\_

**Nickname:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Gender:** \_\_\_\_\_

### RESIDENTIAL ADDRESS

**Street Address 1:** \_\_\_\_\_

**Street Address 2:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

### MAILING ADDRESS

**Street Address 1:** \_\_\_\_\_

**Street Address 2:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Primary Phone:** \_\_\_\_\_

**Alternate Phone:** \_\_\_\_\_

- Phone Type:**
- Home
  - Mobile
  - Work
  - Other

- Phone Type:**
- Home
  - Mobile
  - Work
  - Other

**All services except for TASC send automated reminders to your Primary Phone. Would you like to receive your reminders by call or text? (Text reminders require a mobile phone)**

- Phone Call       Text

**EMERGENCY CONTACT**

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

**ADDITIONAL INFORMATION**

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Have you ever served in the military?       Yes       No

Do you use any mobility devices to help you get where you need to go?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> No              | <input type="checkbox"/> Walker            | <input type="checkbox"/> Powered Chair/Scooter |
| <input type="checkbox"/> Crutches        | <input type="checkbox"/> Car Seat          | <input type="checkbox"/> Bariatric Wheelchair  |
| <input type="checkbox"/> Cane/White Cane | <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Other _____           |

If you use a manual or powered wheelchair or scooter, the following information is required:

Length: \_\_\_\_\_ in.    Width: \_\_\_\_\_ in.

Weight: \_\_\_\_\_ lbs. (Combined person and device)

Do you require the use of a lift or ramp to board a vehicle?       Yes     No

Do you use a service animal?       Yes     No

Do you have any of the following medical conditions?

- Vision Impairment
- Hearing Impairment
- I wear a prosthesis

Do you use any of the following medical devices?

- Oxygen
- Other: \_\_\_\_\_

**Will you travel with a Personal Care Assistant (PCA)?**

- Always     Sometimes     Never

**If found eligible for this service, you will:**

- Be able to meet the vehicle at the curb?
- Need assistance from the door of your pick-up point to the vehicle?
- Need assistance from the vehicle to the door of your destination?

**If someone will accompany you on your trips, are they a child or adult?**

- No one     Child     Adult

**Do you have Medicaid?**     Yes     No

**If appropriate, may we share your contact information with other transportation agencies that may be able to help you?**

- Yes     No

**Does anyone have a Durable Power of Attorney on your behalf?**     Yes     No

**Other Comments**

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## SERVICE-SPECIFIC QUESTIONS

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### COAST ADA

Have you ever had ADA paratransit service in another location?  Yes  No

If yes, where? \_\_\_\_\_

Please identify all conditions that affect your ability to use the COAST fixed-route bus system and describe how it affects your ability to ride the bus.

Condition: \_\_\_\_\_

Effect: \_\_\_\_\_

Condition: \_\_\_\_\_

Effect: \_\_\_\_\_

Condition: \_\_\_\_\_

Effect: \_\_\_\_\_

Is your condition temporary?  No  Yes, expected end date: \_\_\_\_\_

I don't know

Using a mobility aid or on your own, how far are you able to travel without the assistance of another person?

less than 200 feet

1/4 mile

1/2 mile

3/4 mile

more than 3/4 mile

Other Comments \_\_\_\_\_

**If you are found to be eligible for this service, you will:**

- be able to meet the vehicle at the curb.
- need assistance from the door of your pickup point to the vehicle.
- need assistance from the vehicle to the door of your destination.

**Check each of the following conditions that would prevent you from getting to and from stops without the assistance of another person.**

- |                                     |  |
|-------------------------------------|--|
| Steep hills                         | No sidewalks                             |
| No curb cuts in sidewalks           | No crosswalks                            |
| Snow or ice                         | Heavy rain                               |
| Hours of darkness                   | Intersections without pedestrian signals |
| Cold weather below ____F            | Hot weather above ____F                  |
| Air pollution above:                |  |
| ____ Unhealthy for sensitive groups | ____ Unhealthy                           |
| ____ Very unhealthy                 | ____ Action days                         |

**In good weather, once you get to a bus stop, how long can you wait:**

- If there is no shelter or bench \_\_\_\_\_ min.
- If there is a bench only \_\_\_\_\_ min.
- If there is a shelter with a bench \_\_\_\_\_ min.

**Do you currently ride the COAST fixed-route buses?**

- Yes How many days per month? \_\_\_\_\_
- No If no, please answer the next question

**Have you ever ridden COAST fixed-route buses?**

- Yes
- No I stopped riding because \_\_\_\_\_

**If you were going to ride a fixed-route bus, would you be able to identify the correct bus to board and the destination stop?**

- Yes
- No

If no, please explain: \_\_\_\_\_

\_\_\_\_\_

Would you be able to board and disembark a bus that has a 'kneeler' to lower the first step or a low floor design with no internal stairs?  Yes  No  Never tried

## COMMUNITY ACTION PARTNERSHIP OF STRAFFORD COUNTY

Do you have health insurance?  Yes  No

What is your employment status?  Employed  Unemployed

Last 4 Digits of Your Social Security Number: \_\_\_\_\_

Last grade completed of school? \_\_\_\_\_

Who referred you? \_\_\_\_\_

## TASC

Are you able to get into a truck, van, or SUV with little or no assistance?  Yes  No

Are you able to get in and out of a car with little or no assistance?  Yes  No

Who referred you? \_\_\_\_\_

Are you interested in receiving information about fundraisers?  Yes  No

## READY RIDES

Are you able to get into a truck, van, or SUV with little or no assistance?  Yes  No

Are you able to get in and out of a car with little or no assistance?  Yes  No

Who referred you? \_\_\_\_\_

# COMMUNITY RIDES & PORTSMOUTH SENIOR TRANSPORTATION

## Basis for Eligibility

- I meet the minimum age threshold
  - Community Rides minimum age threshold is 60 years old
  - Portsmouth Senior Transportation minimum age threshold is 62 years old
- I have a 70% disability from the US Department of Veterans Affairs
- I have a Medicare Card
- I have been determined to be disabled by the Social Security Administration (SSA)
- I have a Severe Mental Illness (SMI) or Severe and Persistent Mental Illness (SPMI)
- I have a qualifying disability

**Please identify all conditions that affect your ability to ride in an automobile with noaccessibility features.** *Accessibility features include things such as ramps, lifts, and wheelchair securements.*

**Condition:** \_\_\_\_\_

**Effect:** \_\_\_\_\_

**Condition:** \_\_\_\_\_

**Effect:** \_\_\_\_\_

**Is your condition temporary?**  No  Yes, expected end date: \_\_\_\_\_

I don't know



## ROCKINGHAM NUTRITION & MEALS ON WHEELS

**Please select the racial or ethnic category or categories with which you identify:**

- African American
- Hispanic Origin
- American Indian or Alaska Native
- Asian American or Pacific Islander:
- Non-Minority (none of the above):

**Why do you require service?**

- I no longer drive/I never drove
- I have a disability that prevents me from driving:
- Other \_\_\_\_\_

**Are you able to get into a truck, van, or SUV with little or no assistance?**    Yes    No

**Are you able to get in and out of a car with little or no assistance?**    Yes    No

**Income Range**

- None
- \$1,277/month or less
- \$1,277/month or more

Release of information and applicant signature:

I understand that the purpose of this application is to determine my eligibility to use:

- COAST ADA Paratransit
- COAST Portsmouth Senior Transportation
- TASC (Transportation Assistance for Seacoast Citizens)
- Rockingham Nutrition & Meals on Wheels Senior Shuttle
- Community Rides
- Ready Rides
- Community Action Partnership of Strafford County Senior Transportation

I agree to release the information herein to TripLink. I understand that TripLink will share the completed Application with the listed Transportation Providers. The Transportation Providers are responsible for determining my eligibility and reserve the right to request additional information needed for this evaluation.

I certify that the information in this application is true and accurate. I understand that falsification of information may result in denial of service. I understand all information will be kept confidential, and only the information required to provide the services I request will be disclosed to those who perform those services.

I confirm the I have read, understood, and agreed to the terms of the release of my information, and that I am submitting on my own behalf, or am authorized to submit for the applicant.

Signature of applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of healthcare proxy (if applicable): \_\_\_\_\_

Date: \_\_\_\_\_