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. If you are applying for ADA Paratransit, Portsmouth Senior Transportation, or Community Rides, you may also need to submit the Medical Release at the end of the application.

TripLink
42 Sumner Drive
Dover, NH 03820

Phone: 603-834-6010
Fax (toll-free): 855-975-2546

SERVICES

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

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

Have you ever served in the military? ☐ Yes ☐ **N**o

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

☐ No	☐ Walker	☐ Powered Chair/Scooter
☐ Crutches	☐ Car Seat	☐ Bariatric Wheelchair
☐ Cane/White Cane	☐ Manual Wheelchair	☐ 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? ☐ **Y**es ☐ 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

SERVICE-SPECIFIC QUESTIONS

COAST ADA

All ADA applicants must submit the Medical Release with their application

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 *(Applicants who check this box must submit the Medical Release with their application)*

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: _____

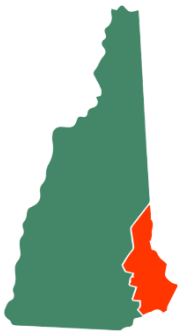
Signature of healthcare proxy (if applicable): _____

Date: _____

Alliance for Community Transportation (ACT)

Working to expand affordable and efficient community transportation in southeastern New Hampshire

TripLink



BARRINGTON
BRENTWOOD
BROOKFIELD
DOVER
DURHAM
EAST KINGSTON
EPPING
EXETER
FARMINGTON
FREMONT
GREENLAND
HAMPTON
HAMPTON FALLS
KENSINGTON
KINGSTON
LEE
MADBURY
MIDDLETON
MILTON
NEW CASTLE
NEW DURHAM
NEWFIELDS
NEWINGTON
NEWMARKET
NEWTON
NORTH HAMPTON
NORTHWOOD
NOTTINGHAM
PORTSMOUTH
ROCHESTER
ROLLINSFORD
RYE
SEABROOK
SOMERSWORTH
SOUTH HAMPTON
STRAFFORD
STRATHAM
WAKEFIELD

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Dear Health Care Professional:

I have completed a TripLink Common Application and am applying for the following transportation services:

- ☐ COAST's ADA Paratransit Service
- ☐ COAST's Portsmouth Senior Transportation
- ☐ ACT's Community Rides

Part of this application process requires a health care professional to review the information I have provided and to make a determination of my functional ability. Eligibility for this service is a functional determination, not a medical one.

I hereby authorize you to provide this information by completing the Evaluation(s) of Functional Ability and submitting it directly to TripLink. Please read the instructions carefully, as the criterion for each service is different.

You are authorized to discuss this information with TripLink and the Cooperative Alliance for Seacoast Transportation (COAST).

Please complete all Evaluations of Functional Ability that are submitted to you by TripLink.

TripLink
42 Sumner Dr
Dover, NH 03820
Phone: 603-834-6010
Fax: 855-975-2546 (secure)
Email: triplink@communityrides.org

Signature: _____ Date & Time: _____

Signature of Personal Representative: _____ Date: _____

Relationship to patient or authority to act for patient: _____

Term: Unless I otherwise revoke this authorization in writing, this authorization will automatically expire after the use or disclosure requested herein is made, unless otherwise specified.

Revocation: I understand that I may revoke this Authorization at any time by requesting it in writing. The revocation will be effective immediately upon your receipt of my written notice. I understand that the revocation will not have any effect on any action taken in reliance on this Authorization before it received my written notice of revocation.

Potential for Redisclosure: I understand that the person receiving my Protected Health Information may not be required to comply with federal and state
Privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed by my healthcare provider.

The Evaluation of Functional Ability must be completed by a Licensed or Certified:

Physician	Physician Assistant
Licensed Social Worker	Psychologist
Respiratory Therapist	Physical Therapist
Psychiatrist	Audiologist
Nurse Practitioner	Optometrist/Ophthalmologist
Registered Nurse	Case Manager/Worker
Occupational Therapist	

The completed *Authorization for Release of Medical Information* should be submitted to the health care professional or case worker listed below:

Name: _____

Agency: _____

Phone: _____

Address: _____