Mid-Coast Public Transportation

Transportation Support Request

Name:		
Street Address:		**Mailing Address (if different):**
Phone:	**Cell phone:**	**Email:**

Members in the household (including yourself). Do not include children under 18.

	Full name	Date of birth	Medicaid # OR	Last 4 digits of Social Security #
1				
2				
3				
4				
5				
6				

The purpose of the following information is to determine the funding sources for which you may be eligible.

Household income (include all sources).

	Source of income	Amount	Type of documentation provided
1			
2			
3			
***Application will NOT be processed without proof of income.**	**Total**	**$**	

Disability Information

Do you have a disability?	☐ **Yes** ☐ **No**	**Is your disability permanent?**	☐ **Yes** ☐ **No**

What is the nature of your disability?

☐ **Intellectual/developmental**
☐ **Cognitive (i.e., Alzheimer's, Dementia, etc.)**
☐ **Physical**
☐ **Visual**
☐ **Auditory**
☐ **Other (please specify):_____**

Do you use a mobility device?

□ Manual wheelchair □ Electric wheelchair □ Scooter □ Walker or cane

If you use a wheelchair, can you transfer to a seat? □ Yes □ No

****Note: you may be required to provide proof of disability.**

Be sure to complete the reverse side

Mid-Coast Public Transportation
P.O. Box 130, 139 Searsport Avenue, Belfast, Maine 04915| 207-338-4769

Ride Information

Which days of the week do you need transportation? Check all that apply, if you know.

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday

☐ Friday ☐ Saturday ☐ Sunday

What is the purpose of your trip(s)? Check all that apply

☐ Personal ☐ Medical ☐ Dialysis ☐ VA

☐ Education ☐ Employment/Volunteer ☐ Shopping/errands ☐ Cancer Care

☐ Recreation/exercise ☐ Other:_____

Attestation

I am applying for transportation support services for myself, and/or household members, or on behalf of another person. There is no regular access to a personal vehicle in the household. I understand that my completed request does not guarantee that funds will be available. I have provided accurate information and understand that I may be subject to an audit of eligibility.

Applicant, Guardian, or POA signature:_____ Date:_____

Printed name: _____

For Office Use Only

Reviewed (date):_____ Reviewed by: _____

Approved	Program	Comments
☐ Yes ☐ No	DHHS-LX08: Low-income Fee Waiver	
☐ Yes ☐ No	John T. Gorman	
☐ Yes ☐ No	Spectrum Generations	
☐ Yes ☐ No	Maine Cancer Foundation	Referred by:
☐ Yes ☐ No	Other:	
☐ Yes ☐ No	Other:	
☐ Yes ☐ No	Other:	
☐ Yes ☐ No	Discounted Mileage Rate	

Application Period: _____/_____/_____ through _____/_____/_____

The Transportation Support Program is made possible through the generous support of our partners.

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

JOHN T. GORMAN FOUNDATION

spectrum generations

MCF Maine Cancer Foundation