



**Benton County
Special Transportation Assistance
Application Form**

PLEASE READ CAREFULLY!

This application will be reviewed and eligibility will initially be determined by Benton County Special Transportation staff in accordance with program eligibility criteria established under the Oregon Elderly and Disabled Special Transportation Fund statutes and regulations (ORS 391.800; OAR Chapter 732); Oregon Department of Transportation Special Transportation Fund Guidelines; as adopted by the Benton County Board of Commissioners.

The Special Transportation Fund (STF) program provides and promotes Benton County public transportation options for individuals 60 years of age or older; persons with disabilities of any age who cannot access fixed modes of public transportation such as Benton County Transit, Corvallis Transit System (CTS) routes, or other personal transportation; as well as other under-served populations such as eligible individuals residing in or traveling to rural Benton County areas not served by Benton County fixed-route service or CTS. More information can be found online at this website:

<https://www.co.benton.or.us/publicworks/page/special-transportation-services>

It is very important that the form is filled out completely. Any incomplete applications will be returned to you without being processed. Staff may consult with appropriate professional experts regarding your eligibility at any stage of the certification process if it is deemed necessary. Submission of this application does not guarantee eligibility.

Staff determination of your eligibility will be communicated by phone or by email or other acceptable format if requested. In the case of a denial, the communication will be in writing and the reason(s) will be noted. If eligibility is made conditional or denied, you will be notified of the appeals process in the written communication.

Upon completion of this application, please return it to:

**Benton County Special Transportation Program
Attention: STF Eligibility
Post Office Box 1083
Corvallis, OR 97339**

If you have any questions regarding eligibility or about this application, please contact the Special and Rural Transportation Coordinator at 541-754-1748.

Alternative versions of this application form such as large print or an orally administered application process can be made available upon request to the Coordinator by calling the above number.

For Office Use Only Date Approved: _____ Date Denied: _____
--



**SPECIAL TRANSPORTATION
PROGRAM ELIGIBILITY APPLICATION**

PLEASE TYPE OR PRINT CLEARLY - APPLICATION MUST BE COMPLETE.

Today's Date: _____

SECTION 1 APPLICANT'S INFORMATION

Applicant's Name: _____ Date of Birth _____

Home Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different): _____

City: _____ State: _____ Zip: _____

Telephone Number: (Home) _____ (Other) _____

Email Address: _____

Emergency Contact Person _____

Relationship of Emergency Contact to Applicant: _____

Emergency Telephone Number: (Home) _____ (Other) _____

SECTION 2 REPRESENTATIVE'S INFORMATION

If you are filling out this application for someone other than yourself, you must complete the following:

Relationship to Applicant: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____

Email Address: _____

SECTION 3 **DISABILITY INFORMATION**

TO BE COMPLETED BY THE APPLICANT OR BY A REPRESENTATIVE

1. Do you have a disability? YES NO

2. If yes, please completely describe the disability that prevents you from using your own personal transportation or a general public transit bus.
Use an additional sheet of paper if needed. You may attach supporting documents that describe your disability if you wish.

3. Is your disability: Temporary Permanent
If Temporary, how long do you expect it to last? / /

4. Do you use a mobility aid(s)? If yes, check the appropriate aid(s):

<input type="checkbox"/> Manual Wheelchair	<input type="checkbox"/> Crutches
<input type="checkbox"/> Powered Wheelchair	<input type="checkbox"/> Service Animal
<input type="checkbox"/> Powered 3-Wheeler	<input type="checkbox"/> Prosthetic Device
<input type="checkbox"/> Cane	<input type="checkbox"/> Orthotic Device
<input type="checkbox"/> Walker	<input type="checkbox"/> Other _____
<input type="checkbox"/> Personal Care Attendant	

5. Do you require someone to assist you when you use public transportation?

YES NO SOMETIMES

If "Yes" or "Sometimes", please explain: _____

6. Are you able to get from your home to the curb without help from another person?

YES NO

7. Are you capable of using a public transit bus or taxi?

YES NO SOMETIMES DON'T KNOW

If "No", why not?

I am unable to board or disembark from a bus or taxi without assistance.

I am unable to board or disembark from a bus or taxi within a reasonable amount of time.

Other reason: _____.

AFFIRMATION OF TRUE AND ACCURATE INFORMATION

I swear or affirm that the information provided in this application is true and correct. I understand that deliberately providing false information may jeopardize the receipt of services. I further understand that the information provided in this application process will be used by Benton County Special Transportation, its agents and employees, for the express purpose of determining eligibility and providing specialized transportation services and shall be kept confidential. I further understand and agree that my eligibility to use special transportation services may be reviewed at any time during the period of certification, if I am certified as eligible, and that my continued use of transportation services is subject to my behavior in accordance with the rules of conduct for passengers. I hereby authorize Benton County Special Transportation staff to verify the information provided in this application, if and as may be required.

**Applicant's Signature
or Signature of Legal Guardian**

Date

NOTE: If Applicant is unable to sign and there is no assigned Legal Guardian, both signatures below are needed:

Signature of person completing form

Date

Signature of Witness*

Date

* Relationship to Applicant: _____

RELEASE OF MEDICAL INFORMATION - AUTHORIZATION

In order to allow the Special Transportation Program to evaluate your request for transportation services, it **may** be necessary to contact a physician or other medical professional, either to confirm the information you have provided, or to address a functional question regarding your disability as relates to the manner in which we provide safe and effective transportation services.

Please list the name, address, and phone number of a health care professional, which may be your primary care physician, other health care professional or rehabilitation professional familiar with your disability, who may be contacted by a Special Transportation Program representative, if verification of information or a practical question requiring healthcare expertise is required.

The following Physician _____, Health Care Professional _____, or Rehabilitation Professional _____ (check one) is familiar with my disability and is authorized to provide information to the City of Corvallis or its authorized representative required to evaluate my eligibility for paratransit service.

Name _____

Address _____

Phone Number _____ Fax Number _____

Print Your Name _____ Date of Birth ____/____/____

Signed _____ Date ____/____/____
(Applicant or Legal Guardian)

NOTE: Refusal to authorize this release of information may result in denial of certification if the Special Transportation Program is either unable to determine that the applicant is eligible, or is not able to address critical care-related issues pertinent to providing safe transportation, without access to information from the health care professionals listed above.