Client Name:

Transportation Assistance Service

Application and Instructions

To aid and enhance the lives of those affected by Sickle Cell

Transportation Assistance Service

Martin Center Sickle Cell Initiative is a 501(c) (3) human services agency dedicated to aiding and enhancing the lives of those impacted by Sickle Cell Disease and Sickle Cell Trait in Central Indiana. Our programs include support and education for Sickle Cell and associated disorders. Through education, outreach, school partnerships, medical provider collaborations and advocacy, we endeavor to provide holistic services for those affected by Sickle Cell. Martin Center Sickle Cell Initiative assists the entire Sickle Cell community by providing solutions that address today's needs and reduce tomorrow's barriers for individuals and their families including providing transportation assistance to and from medical appointments, Martin Center Sickle Cell Initiative and selected Martin Center Sickle Cell Initiative events for individuals with Sickle Cell or other related blood disorders.

Eligibility

Candidates for the Martin Center Sickle Cell Initiative Transportation Assistance Service must:

- Be an adult with Sickle Cell Disease or a parent/guardian of a child with Sickle Cell Disease or an associated disorder and a resident of Marion, Hamilton, Hancock, Morgan, Hendricks, or Boone Counties in Indiana.
- Complete and submit the attached application for the Transportation Assistance Service.
- Have transportation issues that prohibit the ability to keep medical appointments, visit Martin Center and/or participate in Martin Center events.
- ***Include documentation that you have exhausted Medicaid transportation services for the year***

Application Procedure

Eligible applicant must complete and submit the entire application.

A Completed application includes:

1. Proof of residency
2. Proof of income for **all** household members who earn an income
3. Proof that the client has **exhausted** Medicaid Transportation services available if applicable

The client and/or guardian is responsible for submitting all of the materials to Cortney Owens in person at Martin Center Sickle Cell Initiative by email to: cowens@TheMartinCenter.org or by fax at 317-927-5167.

Selection Criteria

Candidates are advised that this is a needs-based service. The number of participants assisted will be dependent upon the availability of funds.

Assistance will be based on a demonstrated need for transportation assistance.

Qualified clients may receive up to $250 worth of transportation assistance per calendar year with an opportunity to grow the benefit to $500 at the discretion of The Martin Center Sickle Cell Initiative Staff

Selection Criteria (continued)

Accounts will be monitored and can be altered (reduced) at the discretion of the Martin Center Sickle Cell Initiative Staff to ensure that our organization is serving all clients effectively

Martin Center will evaluate all applications with fairness and regard for the challenges faced by each applicant.

Martin Center will reserve the right to conduct interviews with applicants if it feels it is necessary to do so in order to make its final decision.

Qualifying Income Guideline

No. of people in your household	Total monthly income	Total yearly income
1 person	less than $3,204 a month	less than $38,450 a year
2 people	less than $3,663 a month	less than $43,950 a year
3 people	less than $4,121 a month	less than $49,450 a year
4 people	less than $4,579 a month	less than $54,950 a year
5 people	less than $4,961 a month	less than $59,530 a year
6 people	less than $5,313 a month	less than $63,750 a year

Transportation Assistance Service Application

CLIENT NAME:

GUARDIAN NAME (IF APPLICABLE): | DATE:

ADDRESS: | CLEINT'S HEMOGLOBIN TYPE:

CITY, ZIP: | CLIENT'S DATE OF BIRTH:

CONTACT INFORMATION: | CLIENT'S SOCIAL SECURITY NUMBER:

Citizenship Status:
☐ U.S. citizen
☐ Non-Citizen, Eligible to Work
☐ Non-Citizen

HOME PHONE: | WORK: | CELL:

EMAIL:

Head of Household's Education:
☐ High School Diploma ☐ Some College
☐ GED ☐ College Degree

Last School Attended:_________________________

Highest Grade Completed:______________________

Client's Gender:
☐ Male
☐ Female

Race/Ethnic Group:
☐ White
☐ Black or African American
☐ Hispanic or Latino
☐ American Indian or Alaskan Native
☐ Asian
☐ Hawaiian or Pacific Islander
☐ Other

Marital Status of Head of Household:
☐ Single
☐ Married
☐ Divorced
☐ Separated
☐ Widowed

Individual with Disabilities:
☐ Yes ☐ Ambulatory
☐ No ☐ Non Ambulatory
If yes, please provide explanation:

Emergency Contact: Name, Phone# and relationship

TYPE OF TRANSPORTATION ASSISTANCE REQUESTED:
☐ Taxi ☐ Bus Pass ☐ Gas Card

Housing Type:
☐ Own home ☐ Renting apartment
☐ Renting house ☐ Living with family and/or friends

DESCRIBE HOW THIS ASSISTANCE WILL HELP RESOLVE THE CURRENT SITUATION:

Current Employment Status:
☐ Not Employed
☐ Underemployed
☐ Employed
☐ Full Time
☐ Part Time

Field of Work:

Income Source(s):
☐ TANF ☐ SSI ☐ Child Support ☐ WIC
☐ Employment ☐ Spouse's Job ☐ Parent Job ☐ SSDI ☐ Other
☐ SS Survivor Benefits ☐ Unemployment
☐ Food Stamps

Gross Monthly Income:
Individual$_________________________________
Household $_________________________________

Are you aware of Medicaid Transportation Assistance? ☐ Yes ☐ No

Have you accessed the Medicaid Transportation Assistance program? ☐ Yes ☐ No

Are you currently eligible for Medicaid Transportation Assistance? ☐ Yes ☐ No

If you answered yes, have you exhausted your Medicaid Transportation Assistance for the year? ☐ Yes ☐ No

Applicants who have not exhausted their Medicaid Transportation Benefits for the year may not be eligible for the transportation program or may have a limited enrollment in the program.

By signing below, I certify that I will use the Martin Center Sickle Cell Initiative Transportation Assistance Service only for medical appointments, visits to Martin Center Sickle Cell Initiative and/or visits to Martin Center Sickle Cell Initiative events. I also certify that the statements herein are true to the best of my knowledge and grant my permission for the information contained within to be shared with Martin Center Sickle Cell Initiative staff.

Client/Guardian Signature: | Date:

MCSCI USE ONLY:

MC Staff Signature: | Date:

President/CEO Signature: | Date:

Date Card/Pass Issued: | Card/Pass #: | Date:

TAS Application Number: TAS 20__ | Approved: ☐ Denied: ☐ | Amount Approved: $