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Indianapolis, IN 46240
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CICOA
Aging & In-Home Solutions

MY FREEDOM PROGRAM ELIGIBILITY APPLICATION

(My Freedom Application & Medical Verification Form is required in order to begin processing)

This program is designed to serve seniors aged 60 or older or individuals of any age with a disability who have difficulty using regular public transportation due to their disability. **Program utilization requires cross county transit or can be utilized within same county in one of the following counties: Boone, Hamilton, Hancock, Hendricks, Johnson, Morgan, Shelby or Madison.**

Last Name: _____ First Name: _____ Middle Initial: _____

Birth Date: _____/___/_____ Gender: ☐Male ☐Female ☐Other Veteran Status: Yes ☐ No ☐

Marital Status: ☐Married ☐Divorced ☐Widowed ☐Single ☐Other

Ethnicity: ☐African American ☐Alaska Native ☐Asian ☐Caucasian ☐Hispanic ☐Native American ☐Other

Street Address: _____ Apt #: _____

City: _____ State _____ Zip Code: _____

Home Phone Number : (____) _____ Cell Phone Number: (____) _____

Mailing Address (if different from above): _____

Email Address: _____

County: ☐Boone ☐Hamilton ☐Hancock ☐Hendricks ☐Johnson ☐Marion ☐Morgan ☐Shelby ☐Madison

EMERGENCY CONTACT INFORMATION (at least one valid contact is mandatory) [POA = Power of Attorney]

Primary Contact Name: _____ Relationship: _____ POA: Y/ N

Home Phone: (____) _____Cell Phone: (____) _____ Email Address: _____

Secondary Contact Name: _____ Relationship: _____ POA: Y/ N

Home Phone: (____) _____Cell Phone: (____) _____ Email Address: _____

☒I authorize CICOA Aging & In-Home Solutions to contact the people listed here on my behalf.

Please indicate if you are going to any of the following:

☐Employment ☐Dialysis; If yes, list treatment days: _____ Will you be crossing county lines? ☐Yes ☐No

Are you currently a certified IndyGo Open Door Rider? ☐Yes ☐No If yes, certified until: ____/____/_____

How did you hear about the Program? ☐Advertisement ☐Church

☐Community Organization ☐Family/Friend ☐Medical Care Provider ☐Online/Website ☐Social Worker

☐CICOA Staff (please provide name: _____) ☐Other:_____

How many people in the household are 60 years or older? ☐0 ☐1 ☐2 ☐3

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Check the box below that most closely matches your monthly income. If there are two or more persons living at your residence who are age 60 or older, you must also include the income of those persons as well.

Family of **ONE**	Family of **TWO**	Family of **THREE**
☐ $0 – $958	☐ $0 – $1,293	☐ $0 – $1,628
☐ $959 - $1,273	☐ $1,294 - $1,719	☐ $1,629 - $2,165
☐ $1,274 - $1,676	☐ $1,720 - $2,262	☐ $2,166 - $2,848
☐ Over $1,676	☐ Over $2,262	☐ Over $2,848

Living arrangements: ☐Rent ☐Own ☐Live with family/friend ☐Assisted Living ☐Nursing Facility ☐Other

Tell us other ways you usually get around town:

☐Personal Vehicle ☐Family/Friends ☐Public Transportation ☐Walk ☐Other Transportation Program

Which of the following **mobility aids** do you use? **Please check all that apply.**

☐Walking Cane	☐Manual Wheelchair	☐Service Animal
☐White Cane	☐Power Wheelchair	☐Communication Board
☐Walker	☐Power scooter/cart	☐Leg Braces
☐Prosthesis	☐Ability to transfer self from	☐Other: _____
☐Crutches	Wheelchair to vehicle seat	
☐Portable Oxygen		☐ NONE

*If you marked Manual wheelchair, power wheelchair or power scooter above, indicate weight of mobility aid, weight of self, width and length of wheelchair. This information is needed to make sure our fleet can provide you safe and adequate transportation.

Mobility aid weight ___ lbs Client weight ___lbs Width of chair _____ Length of chair _____

Do you have a visual impairment? ☐Yes ☐No Do you have a hearing impairment? ☐Yes ☐No

Do you require an attendant accompany you to provide assistance when using transportation services?

☐Yes ☐No ☐Sometimes

Please describe your health condition or disability and **how this prevents you from using regular public transportation**:

_____

_____

_____

Please describe any problems you have **understanding and remembering how to use a regular city bus**:

_____

_____

_____

APPLICANT'S CERTIFICATION

I understand the purpose of this form is to determine if I am eligible to participate in the My Freedom program offered through CICOA Aging & In-Home Solutions. I understand this program is designed to serve individuals seniors aged 60 years or older or individuals of any age with a disability who have difficulty using regular public transportation due to their disability. I certify the information I have provided on this intake form is true and accurate to the best of my ability.

I agree any transportation fare purchased is for my personal use only. I agree not to give or sell my fare to another individual. I acknowledge that giving or selling my fare to other individuals may prevent continued participation in the My Freedom program.

FOR OFFICE USE ONLY: DATE RECEIVED: _____ DATE ENTERED: _____

Applicant Signature: _____ Date: _____/_____/_____

Person completing form for Applicant (if applicable): _____

Relationship: _____ Date: _____/_____/_____

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

I authorize the CICOA Aging & In-Home Solutions to obtain medical information from (list physicians below):

_____

_____

as needed for the eligibility screening process and general coordination of the Transportation Voucher program.

Applicant Signature: _____ Date: _____/_____/_____

HIPAA NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

☒I acknowledge that I received the HIPAA Notice of Privacy Practices for Protected Health Information from CICOA's Aging & In-Home Solutions

Applicant Signature: _____ Date: _____/_____/_____

FOR OFFICE USE ONLY: DATE RECEIVED: _____ DATE ENTERED: _____