COMPLETE PAGES 1-7

Human Service Transportation Applications

Trans ID _____

☐ ARC of Maui ☐ Kalima O'Maui ☐ Rural Shopping Shuttle	☐ Day Care ☐ Day Health ☐ I-Shuttle	☐ Ala Hou* ☐ Easter Seals ☐ Kaunoa Leisure / Wellness	☐ Dialysis* ☐ Youth Trans ☐ Senior Club	☐ Employment to Work for Low Income/Disabled Individuals**

Name	**Birthdate**	**Sex** ☐ Male ☐ Other ☐ Female ☐ Unknown

Address	**City**	**State**	**Zip Code**

Mailing Address	**Phone Day**	**Evening**	**TDD/TTY**

Health Insurance	**Race**	**Ethnicity**	**Age**
☐ NO Insurance ☐ Medicaid ☐ Medicare ☐ State Children's Health Ins. ☐ State Adult Health Ins. ☐ Military Health Care ☐ Direct-Purchase ☐ Employment Based ☐ Unknown / Not Reported	☐ White ☐ Multi-race (2 or more) ☐ African American or Black ☐ Asian ☐ Native Hawaiian & Other Pacific Islander ☐ American Indian/Alaskan Native ☐ Unknown / Not Reported ☐ Other	☐ Hispanic, Latino or Spanish origin ☐ NOT Hispanic, Latino or Spanish origin ☐ Unknown / Not Reported	☐ 0-5 ☐ 6-13 ☐ 14-17 ☐ 18-24 ☐ 25-44 ☐ 45-54 ☐ 55-59 ☐ 60-64 ☐ 65-74 ☐ 75+ ☐ Unknown / Not Reported

Disabling Condition	**Disconnected Youth**	**Military Status**	**Work Status**
☐ Yes ☐ No ☐ Unknown **Limited English** ☐ Yes ☐ No	☐ Youth 14-24 not working or in school	☐ Veteran ☐ Active Military ☐ Unknown / Not Reported	☐ Employed, Full-time ☐ Employed, Part-time ☐ Unemployed (6 mths or less) ☐ Unemployed (Long-term for more than 6 months) ☐ Unemployed, (not in labor force) ☐ Migrant Seasonal Farmworker ☐ Retired ☐ Unknown/Not Reported

Level of Income	**Marital Status**	**Housing**
See page 3 for gross income declaration	☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Separated	☐ Own ☐ Other permanent Housing ☐ Rent ☐ Other _____ ☐ Homeless ☐ Unknown / Not Reported

Education Level

☐ 0-8 ☐ High School Grad / GED ☐ 2 to 4 year College graduate
☐ 9-12/non-graduate ☐ 12+ some post secondary ☐ Unknown / Not Reported

Family/Household Size	**Family/Household Type**
☐ One member ☐ Five members ☐ Two members ☐ Six members or more ☐ Three members ☐ Unknown / Not Reported ☐ Four members	☐ Single Parent Female ☐ Non-related With/Children ☐ Single Parent Male ☐ Multigenerational Household ☐ Single Person ☐ Other:_____ ☐ Two Parent Household ☐ Unknown / Not Reported ☐ Two Adults NO Children

Mobility (Check appropriate item(s) **PCA Required** ☐ Yes ☐ No (limited to one)

☐ No limitation ☐ Ambulatory ☐ Power Chair
☐ Scooter ☐ Wheelchair ☐ Walk Aid Type _____
☐ Child Restraint Seat ☐ Gurney ☐ Other _____

Annual Household Income

See page 3

Source of Family Income

☐ Employment ONLY
☐ Employment + Other ONLY
☐ Employment + Other + Non-cash Benefits
☐ Employment + Non-cash Benefits
☐ Other Sources ONLY
☐ Other + Non-cash Benefits
☐ NO Income
☐ Non-Cash Benefits ONLY
☐ Unknown / not reported

Please report the types of Other income and/or Non-cash Benefits received by the households who reported sources other than income

Other Income Source

☐ TANF
☐ SSI
☐ VA Service disability Comp
☐ VA Non-Service Disability Pension
☐ Private Disability Insurance
☐ Workers Compensation
☐ Retirement Income from Social Security
☐ Social Security Disability Insurance (SSDI)
☐ Unemployment Insurance
☐ Pension
☐ Child Support
☐ Alimony or other Spousal Support
☐ Unemployment Insurance
☐ EITC
☐ Other, Unknown / Not Reported

Non-Cash Benefits

☐ SNAP ☐ Housing Choice Voucher ☐ HUD - VASH ☐ Other
☐ WIC ☐ Public Housing ☐ Childcare Voucher ☐ Unknown / Not Reported
☐ LIHEAP ☐ Permanent Supportive Housing ☐ Affordable Care Act Subsidy

Military Status

Emergency Contact	**Relationship**	**Address**	**Phone Day**	**Evening**

Client Signature	**Date**

Work History

Must be completed if **Employment to work for low Income/disabled selected

Name and location of Employer _____

☐ **Sunday**	☐ **Monday**	☐ **Tuesday**	☐ **Wednesday**	☐ **Thursday**	☐ **Friday**	☐ **Saturday**
From:	**From:**	**From:**	**From:**	**From:**	**From:**	**From:**
To:	**To:**	**To:**	**To:**	**To:**	**To:**	**To:**

(This part is to be completed by a licensed physician or agency involved in programs for the disabled)
*Must be completed if **ALA Hou** service or **Dialysis** selected.

Please specify nature of applicant's disability

Agency/Name	**Mailing Address**	**Telephone #**

Signature _____ **Date** _____

For Office Use Only

Application ☐ Approved ☐ Disapproved ☐ Eligible Programs

Notification Date: _____

Eligibility Certification by: _____

Comment: _____

_____

● P.O. Box 2122, Kahului, Maui, HI 96733 ● Tel. No. 877-7651 ● Fax No. 871-2171 ● Rev. 04-25-19 ●

INCOME VERIFICATION - Required for all programs

NOTE: TO BE ELIGIBLE FOR EMPLOYMENT TO WORK SERVICE, YOU MUST SUBMIT A COPY OF YOUR MOST CURRENT TAX RETURNS

200% OF THE 2024 FEDERAL POVERTY GUIDELINES FOR HAWAII

Persons in Family/Household Poverty Guidelines	Annual	Monthly
1	$34,620	$2,885
2	$47,000	$3,917
3	$59,380	$4,948
4	$71,760	$5,980
5	$84,140	$7,012
6	$96,520	$8,043
7	$108,900	$9,075
8	$121,280	$10,107
9	$133,660	$11,138
10	$146,040	$12,170
For families/households with more than ten people, add $12,380 to the annual for each additional person.		

**You must submit proof of income in order to qualify for the Employment to Work for Low income or Disabled Individuals. Acceptable proof is the most current tax returns for all household members, or pay stubs for the last three pay periods for all household members.

Maui Economic Opportunity, Inc.
P.O. Box 2122
Kahului, HI 96733
808-249-2990 Fax: 808-249-2991
www.meoinc.org

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling 808-249-2990, extension 342, or by requesting one at the MEO offices.

_____ _____

Date Signature

_____

(Print or Type Name)

*As the representative of the above individuals, I acknowledge receipt of the Notice on his or her behalf.

_____ _____

Signature Relationship

_____

Date

MAUI ECONOMIC OPPORTUNITY, INC.

PARTICIPANT'S WAIVER OF CLAIM AND INDEMNITY

For and in consideration of Maui Economic Opportunity, Inc. providing me transportation service, I, _____
, on behalf of myself, my sibling(s), parent(s), child(ren), relatives, heirs, estate, executors, and /or administrators, hereby waive, release, discharge, hold harmless and indemnify Maui Economic Opportunity, Inc., its officers and employees (hereafter the "Transportation Agency"), from and against any and all claims, suits, damages, costs, fees, (including, but not limited to, reasonable attorney's fees), losses, expenses, causes of action, judgments, and liabilities of every nature or kind (collectively "liabilities"), in equity or law, in any manner arising out of or in connection with the Transportation Agency providing me transportation service, unless such liabilities are caused by the gross negligence or willful misconduct of the Transportation Agency.

I agree to abide by all bus and safety rules of the Transportation Agency.

If any provision of this agreement, or the application of same is held invalid, all remaining provisions of this agreement and the application of such provisions to circumstances other than those which are held invalid shall not thereby be held invalid, and to this end the provisions of this agreement are expressly understood and agreed by the parties to be severable.

_____

PRINT PASSENGER'S NAME ABOVE

_____

LEGAL GUARDIAN SIGNATURE (SELF OR OTHER)

_____

DATE

OPTIONAL SIGNATURES

I have read, understand, and agree with the provisions in this waiver form.

_____ _____

Parent/Guardian Date

NOTICE OF PRIVACY PRACTICES

May 2017

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures of Health Information

We may use health information about you to determine program eligibility or to obtain payment for service (such as sending billing information to a health insurance plan), for administrative purposes, and to evaluate the quality of service that you receive (such as comparing client data to improve service methods).

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, abuse or neglect reporting, auditing purposes, research studies, workers' compensation purposes, and emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the lobby of each office, and on our Web site. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Individual Rights

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we may charge you a small fee for each page. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than service, payment, or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You have the right to request that your health information be communicated to you in a confidential manner such as sending mail to an address other than your home. If this notice was sent to you electronically, you may obtain a paper copy of the notice.

You may request in writing that we not use or disclose your information for eligibility, payment, or administrative purposes or to persons involved in your care except when specifically authorized by you, when required by law, or in emergency circumstances.
We will consider your request but are not legally required to accept it

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request. Under no circumstance will you be retaliated against for filing a complaint.

Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.
If you have any questions or complaints, please contact:

Gay Sibonga, Chief Operating Officer
PO Box 2122
Kahului, HI 96733
808-249-2990 extension 342
gay.sibonga@meoinc.org