



7101 WYOMING STREET, WESTMINSTER, CA 92683  
 TRANSPORTATION DEPARTMENT PHONE: (714) 891-9500 FAX: (714) 893-4819  
 LYDIA ORTEGA [lydia.ortega@abrazarinc.com](mailto:lydia.ortega@abrazarinc.com), JOSE MENDOZA [j.mendoza@abrazarinc.com](mailto:j.mendoza@abrazarinc.com) or  
 KHANH NGUYEN [k.nguyen@abrazarinc.com](mailto:k.nguyen@abrazarinc.com)

**ABRAZAR SNEMT PROGRAM APPLICATION**  
PLEASE SIGN AND DATE ALL FORMS PRIOR TO SUBMITTING. INCOMPLETE APPLICATIONS WILL BE RETURNED.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ **Age (60):** \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

Address: \_\_\_\_\_ Apartment/Unit #: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cell (2<sup>nd</sup> Phone #): ( ) \_\_\_\_\_

1. Have you ever applied for OCTA ACCESS?  Yes  No  
 If yes, were you issued an ID #, if Yes please list? \_\_\_\_\_  Yes  No  
 If yes, are you able to utilize **OCTA ACCESS**?  Yes  No

2. Do you have any physical or functional limitations?  Yes  No  
 If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_

3. Do you require a mobility device or special equipment for transport?  
 Please check all that apply:  Yes  No  
 Cane \_\_\_\_\_ Walker \_\_\_\_\_ Wheelchair \_\_\_\_\_ Scooter \_\_\_\_\_ Oxygen \_\_\_\_\_ Other \_\_\_\_\_  
 If yes, are you able to enter/exit the vehicle without your mobility device?  
 \_\_\_\_\_  Yes  No

Are you able to transfer from a wheelchair to seat with/without assistance?  
 \_\_\_\_\_  Yes  No

4. Will a personal care attendant or assistant be traveling with you?  Yes  No

5. Do you require door-to-door assistance?  Yes  No  
 If yes, please describe reasons why: \_\_\_\_\_  
 \_\_\_\_\_

6. Please list your primary doctor(s) Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Suite #: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Doctor Phone: ( ) \_\_\_\_\_ Note: \_\_\_\_\_
7. How often do you anticipate needing to use the transportation service?  
 Daily \_\_\_\_\_ Weekly \_\_\_\_\_ Monthly \_\_\_\_\_ Other (note) \_\_\_\_\_
8. Emergency Contact Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_
9. How do you get to your medical appointments now? \_\_\_\_\_  
 \_\_\_\_\_
10. Do you own a vehicle and are you able to drive? \_\_\_\_\_  Yes  No

**My signature verifies all information in this application to be true.**

\_\_\_\_\_  
**Applicant signature**

\_\_\_\_\_  
**Date**

**The following information is gathered for statistical data only and does not affect your eligibility:**

How did you hear about the program? \_\_\_\_\_

Ethnic background:  Asian  Black  Hispanic  White  Native American  Other \_\_\_\_\_

**Annual Income per individual (MANDATORY):** \_\_\_\_\_

Financial Hardship Waiver Requested

**PROGRAM USE ONLY**

- Referrals to alternative transportation provided: \_\_\_\_\_
- Exceptions (temporary, unrestrictive etc.): \_\_\_\_\_
- Reason referred to OoA I&A: \_\_\_\_\_
- Need for follow-up contact: \_\_\_\_\_
- Annual Income:  At or below 150% FPG  Above 150%FPG  Financial Hardship Waiver



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**ABRAZAR SNETM PROGRAM WAIVER**  
 PLEASE SIGN AND DATE ALL FORMS PRIOR TO SUBMITTING. INCOMPLETE APPLICATIONS WILL BE RETURNED.

I hereby acknowledge that the transportation is a service provided by ABRAZAR and funded by the County of Orange, Office on Aging. I hereby waive the right to make any claims against ABRAZAR and the County of Orange, Office on Aging or their officials, employees and volunteers, for any injuries, damages, charges or expenses, including attorney’s fees which might be sustained as a result of my participation in the SNETM Program. I also acknowledge that ABRAZAR reserves the right to refuse transportation service.

**PLEASE PRINT:**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Phone:** (\_\_\_\_) \_\_\_\_\_

**Client signature:** \_\_\_\_\_

**Caregiver signature (if applicable):** \_\_\_\_\_

**EMERGENCY CONTACT (1):** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_ **PHONE:** (\_\_\_\_) \_\_\_\_\_

**EMERGENCY CONTACT (2):** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_ **PHONE:** (\_\_\_\_) \_\_\_\_\_

Please return this form to the Transportation Coordinator (s), Lydia Ortega, Jose Mendoza or Khanh Nguyen. **You can mail, fax, or drop off your application in the enclosed envelope.** Services can be scheduled after all forms have been submitted and approved. Confirmation of approval will be mailed within five business days after receipt of completed forms.