BUCKS COUNTY AREA AGENCY ON AGING

APPLICATION FOR TRANSPORTATION SUBSIDY – 65 YEARS OLD OR OLDER

Return to: Bucks County Area Agency on Aging
55 E. Court St., 3rd floor
Doylestown, PA 18901
Attn: Transportation

This is an application to the Area Agency on Aging (AAA) for financial assistance to subsidize my Bucks County Transport, Inc. (BCT) 15% fare. I understand an individual qualifies for the subsidy if his/her annual household income is $14,500 or less for an unmarried individual or $17,700 or less for a married couple **and does not** receive services through the Medicaid Waiver program. Transportation is obtained by calling BCT directly toll free 1-888-795-0740 or local number 215-794-8360.

If I qualify, I understand that I will be asked to contribute $1.00 a trip (or current contribution rate) and that the Area Agency on Aging will only subsidize trips to:

Adult Day Care
Banking
Bucks Co. Assn. for the Blind
Food Shopping
Library
Medical Appointment
Pharmacy
Senior Center (AAA Contracted Only)
Social Service Appointment
Volunteering (AAA Assignments Only)

I further understand that this approval is subject to Area Agency on Aging funding limitations and may be changed or revoked with notice, as necessary. I can also voluntarily contribute to the cost of service by sending a contribution directly to the Area Agency on Agency at any time.

I have completed the information below and agree that this information can be given to BCT in order to process this application.

Do you receive services through the Medicaid Waiver program ❑ No ❑ Yes
If yes, please contact your Service Coordinator for assistance with transportation.

I HEREBY DECLARE THAT MY TOTAL ANNUAL HOUSEHOLD INCOME IS:

☐ **UNMARRIED** – annual income of $14,500 or less ***(or)***

☐ **MARRIED** – husband and wife combined annual income of $17,700 or less

NAME: ☐Mr. ☐Mrs. ☐Ms. _____
First *Middle Initial* *Last*

RESIDENTIAL ADDRESS: _____

TOWN_____ STATE_____ ZIP_____

MAILING ADDRESS: *(if different than residence)* _____

TOWN_____ STATE_____ ZIP_____

TELEPHONE #: _____ **DATE OF BIRTH:** _____

SOCIAL SECURITY # *(last 4 digits)* _____ **GENDER:** ☐ MALE ☐ FEMALE

MARITAL STATUS: ☐ Divorced ☐ Married ☐ Separated ☐ Single ☐ Widowed

LIVING SITUATION: ☐ Alone ☐ With spouse only ☐ With other family member

ETHNICITY: *(must check 1 of 2 boxes)*
☐ Hispanic/Latino
☐ Not Hispanic/Latino

ETHNIC RACE: *(must check 1 of 7 boxes)*
☐ American Indian/Alaska
☐ Asia
☐ Black/African American
☐ Hawaiian/Pacific Islander
☐ Non-Minority *(White or non-Hispanic)*
☐ White Hispanic
☐ Other

SIGNED _____ **DATE**_____