COMMUNITY DEVELOPMENT
CITY OF PASADENA

CLIENT ELIGIBILITY FORM

In accordance with 24 CFR 570-506, agencies must acquire information to determine client eligibility as well as for general reporting purposes. To participate in this program that is funded by Federal Funds, you must fill out this form completely and accurately. HUD will prosecute false claims and statements.

Program Name: **TRANSPORTATION RIDES PROGRAM**

National Objective 570.208

Benefit to Low and moderate Income Persons:

	Low/Mod Area Benefit
X	Limited Clientele Benefit
	Low/Mod Housing Benefit
	Job Creation or Retention

Aid in the Prevention of Slums or Blight:

	On An Area Basis
	On Spot Basis
	Job Creation or Retention

An Urgent Need:

	Needs having a Particular Urgency

Client Info

Name: _____ Phone Number: _____

Address: _____ City, State, Zip: _____

Date of Birth: _____ Age: _____ TX Drivers Lic. And/or TX ID Number: _____

Is this client a minor? ☐ Yes ☐ No

**Guardian Name: _____

☐ Male ☐ Female ☐ Transgender

Is this client disabled? ☐ Yes ☐ No

Is this client a veteran? ☐ Yes ☐ No

Race: ☐ White ☐ Black ☐ Asian & White ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaskan Native & White ☐ Amer. Indian/Alaskan Native & Black/African Amer. ☐ Black/African American & White ☐ Other Multi-Racial

Ethnicity ☐ Hispanic ☐ Non-Hispanic

Income

Annual Income: _____ Household: _____ Adults(18 yrs-61 yrs) _____Children(17 yrs & under) _____Elderly (62 yrs & older)

Proof of Income: ☐ Social Secrity Award Letter ☐ W-2 Form ☐ Check Stubs ☐ Other _____

Client Income Level ☐ 0-30% ☐ 31-50% ☐ 51-80% **Female the Head of Household?** ☐ **Yes** ☐ **No**

Is the client a resident of Pasadena? ☐ Yes ☐ No

What proof was used to establish permanent residency? _____

(Birth Certificate, driver's license, etc.)

By signing, I certify, under penalty of perjury, that all information contained herein is accurate.

Name _____ Date _____

Signature _____ Relationship to Client: _____

For staff use only

Signature of authorized subrecipient staff: _____

Title: _____ Date: _____

JEFF A. WAGNER
MAYOR

OFFICE USE ONLY
_____COPS
_____COPD

CITY OF PASADENA CDBG
TRANSPORTATION PROGRAM

Name: _____ Date of Birth: ____/____/____
First Last M.I. S.S. #:_____

Address: _____
Street Apt. # City State Zip

Home Phone Number: _____ Alternate Number: _____

Name and Phone Number of Relative, Friend or Neighbor who can usually contact you:

_____	_____	_____	_____
Name	**Relation**	**Home Phone**	**Work Phone**

Race/Ethnicity: _____ Are you the head of household? YES __ NO__ Male __ Female__

(Check One): Single ____ Married ____ Divorced ____ Widowed ____

Number of people in household? _____ Are you able to drive? YES____ NO____

If unable to drive, Please state type of disability _____

Does anyone in your household own a vehicle? YES___ NO____

Texas Driver's License #: _____ OR Texas ID# _____

Total Household Income: $_____ Disabled: YES____ NO____

ALL APPLICANTS MUST:

- List all income sources
- Provide a copy of their Social Security Award Letter
- Provide a copy of last month's bank statement
- If you do not have a bank account, please complete the no bank
- account portion on the Source of Income form
- A completed physicians' disability statement (if under 65)
- A copy of valid driver's license or identification card with picture
- Must provide emergency contact – name and phone number

Low-Income Qualification	
Size of Family Unit	Income Maximum Amount
1	$40,050
2	$45,800
3	$51,500
4	$57,200
5	$61,800
6	$66,400
7	$70,950
8	$75,550

(subject to change)

WITHOUT THIS INFORMATION YOU WILL NOT BE ELIGIBLE FOR THE TRANSPORTATION PROGRAM.

Send information to:
City of Pasadena
Madison Jobe Senior Center
1700 E. Thomas Ave.
Pasadena, TX 77506
713-477-0175

Revision: 04-17

City of Pasadena CDBG Transportation Subsidy
Income Statement

Source of Income	Monthly	Annually
Social Security:	_____	_____
Pension:	_____	_____
Retirement:	_____	_____
Child Support:	_____	_____
TANF: (Temporary Assistance for Needy Families)	_____	_____
Employment Income:	_____	_____
Other:	_____	_____
Total applicants income:	_____	_____
Other Members in household:	_____	_____
Total Household Income:	_____	_____

No Bank Account Statement

If you **do not have a bank account,** please fill out this statement, sign and date. Make sure that you Return this with your paper work.

I, _____, residing at _____,
Currently do not have a checking or a savings account with any banking facility.

_____ _____
Signature of Applicant **Date of Application**

The above named applicant has examined the eligibility requirements of COPS/COPD, subsidized by CDBG grant funding, and has submitted this application for participation in such program after certifying that all of the information so submitted is true and correct. It is expressly understood and agreed that should it be determined at any time by COPS/COPD, its officers, agents and/or employees that this application contains incorrect or incomplete information, the above named individual shall be disqualified from participation in the program and shall be required to repay COPS/COPD all expenses incurred as a result of such individual's participation.

CERTIFICATION:

This section is to be signed by the applicant or by person authorized to sign for client. A witness is needed for any signature made by a mark. I certify this application has been completed to the best of my knowledge with complete and accurate information. I understand any false statements or omissions of facts relevant to my eligibility for assistance will be considered fraud, and that I may be prosecuted under applicable U.S. Codes for this fraud. ***Furthermore, I understand that assistance is contingent upon availability of funds.***

_____ _____ _____
Applicant Date Witness (if signed by a mark indication)

Revision: 4-17

City of Pasadena, CDBG Program, is committed to practicing non-discrimination. If you believe you have been subjected to discrimination you may file a complaint with the Grant Administrator at 713.477.0175.

JEFF A. WAGNER
MAYOR

PHYSICIAN'S DISABILITY STATEMENT

I, the undersigned, certify that I am currently disabled and unable to anticipate in gainful employment.

Name: _____ **Phone Number:** _____

Address: _____ **City:** Pasadena **State:** TX **Zip Code:** _____

Signature: _____ **Date:** _____

The patient named above has applied for assistance from the _____
(CDBG Program Name)

and claims a disability which precludes gainful employment. Any financial charges which result from the completion of this form or from any exam or testing required in the completion of this form are the responsibility of the applicant. Your cooperation in completing the following questions will be appreciated. After completion, please give this letter to the patient who will return to our agency.

Medical information on this report is confidential; becomes the property of, and may be used within the discretion of the City of Pasadena Community Development Department or shared with other governmental agencies to determine eligibility for benefits or rehabilitation services. This medical report may become available to the applicant or the applicant's representative for examination upon request.

To be completed by Licensed Physician (or Optometrist if person is legally blind).

I, a licensed physician or optometrist, hereby certify that _____is currently disabled and that such disability is of a temporary nature / permanent nature continuing for the applicant's lifetime.

Diagnosis:_____

_____

Prognosis:_____

_____

If temporary nature, how long will patient be disabled from work? _____

Name of Physician or Optometrist: _____

Address: _____

City/State/Zip: _____

Phone number: _____

Signature of Physician or Optometrist: _____ Date: _____

Office Use Only:
Grant Code: _____
Agency Code: _____
Registered Date: _____

Keeping Harris County Moving

8410 Lantern Point Drive, Houston, Texas 77054
Main: (713) 368-RIDE (713-368-7433)
Fax: (713) 437-4860

Program Funded by
Federal Transit Administration (FTA)
(Grant funds have expiration dates)

Registration Form

APPLICANT:
First Name: _____ Last Name: _____ M.I.: _____

Sex (M/F): _____ Race/Ethnicity: _____ Date of Birth: _____/_____/_____

Home Number: (_____)_____ Alternate Number: (_____)_____ E-mail:_____

What is your preferred method of contact? E-mail? _____ Home Phone?_____ Alternate Phone?_____ Mail? _____

Primary language spoken in the home (Check One): English __ Spanish __ Vietnamese __ Other _____

(Check One): Single _____ Married _____ Divorced _____ Widowed _____

Address of Applicant:

_____ _____ TX _____
Number Street Apt. # City Zip Code

Mailing Address: (if different from above)

_____ _____ TX _____
Number Street Apt. # City Zip Code

Name and Phone Number of Relative, Friend, or Neighbor who can usually contact you:

_____ _____ (_____) _____ (_____) _____
Name Relation Home Phone Work Phone

Check this status if senior and/or a person with disabilities:
Older Adult(s) (age 65 & above) _____
Person with disabilities _____
Older Adult(s) (age 65 & above) AND person with disabilities _____

Mobility Status (Check One):
Ambulatory (able to walk) _____
Wheelchair User _____

Are you a military veteran?
Yes _____
No _____

Check ALL that apply:
Applied for METROLift _____
Approved for METROLift _____
Denied by METROLift _____

A fee of $30.00 will be charged to you for any stopped payments or returned items.
*** Funds added to the Rides Fare Card are non-refundable & non-Transferable ***

The above named applicant has examined the eligibility requirements of RIDES, subsidized by H-GAC funding, and has submitted this application for participation in such program after certifying that all of the information so submitted is true and correct. It is expressly understood and agreed that should it be determined at any time by RIDES, its officers, agents and/or employees that this application contains incorrect or incomplete information, the above named individual shall be disqualified from participation in the program and shall be required to repay RIDES all expenses incurred as a result of such individual's participation.

CERTIFICATION:
The section is to be signed by the applicant or by person authorized to sign for client . A witness is needed for any signature made by a mark. I certify this application has been completed to the best of my knowledge with complete and accurate information. I understand any false statements or omissions to the best of my knowledge with complete and accurate information. I understand any false statements or omissions of facts relevant to my eligibility for assistance will be considered fraud, and that I may be prosecuted under applicable U.S. Codes for this fraud. Furthermore, I understand that assistance is contingent upon availability of funds.

_____ _____ _____

Applicant ***Date*** ***Witness (if signed by a mark indication)***

The Office of RIDES – Specialized Transportation for Harris County is wheelchair-accessible. Reserved parking spaces are available.

THE FOLLOWING DOCUMENTS ARE REQUIRED:

1.) State Issued Identification Card OR State Issued Drivers License

2.) Proof of Disability:

Acceptable documents (submit (1) of the following):

a.) Doctor's Certification Form

b.) Supplemental Security Income (SSI)

c.) Social Security Disability Insurance (SSDI)

d.) Other Verification

TITLE VI NOTICE

Harris County operates its programs and services without regard to race, color, and national origin in accordance with Title VI of the Civil Rights Act. Any person who believes she or he has been aggrieved by any unlawful discriminatory practice under Title VI may file a complaint with Harris County.

For more information on Harris County's civil rights program and the procedures to file a complaint, contact 713-578-2000, TTY Dial 7-1-1 (1-800-735-2988); email transit@csd.hctx.net; or visit our administrative office at 8410 Lantern Point Drive, Houston, Texas 77054. For more information, visit www.harriscountytransit.com