ST. CHARLES URBAN COUNTY / ST. CHARLES CITY TRANSPORTATION PROGRAM
2022

St. Charles County has accepted a grant from the United States Department of Housing and Urban Development (HUD), to conduct the Community Development Block Grant Program under Title I of the Housing and Community Development Act of 1974 as amended. The goal of this program is to provide transportation for necessary medical, shopping and essential services. The Transportation Program is available to residents of Unincorporated St. Charles County, City of St. Charles, Cottleville, Dardenne Prairie, Lake St. Louis, New Melle, St. Peters, St. Paul, Weldon Spring and Wentzville who meet the criteria and require transportation services.

PROGRAM DESCRIPTION AND GUIDELINES

A. Eligibility – General

In order to be eligible for the Transportation Program, the following criteria must be met:

- Individual must reside within Unincorporated St. Charles County / City of St Charles, or the corporate city limits of Cottleville, Dardenne Prairie, Lake St. Louis, New Melle, St. Peters, St. Paul, Weldon Spring or Wentzville.

- Individual must lack access to a vehicle or be unable to drive.

- Individual is low-income, or disabled and meets the 2022 low-moderate income qualifications. In order to be eligible for this program, income must be verified for all applicants regardless of age, or disability. Supporting documentation required:
  - Please submit proof of all income you receive monthly, quarterly or yearly along with your 2021 federal income tax return (if required to file).
  - Please submit statement copies of checking or savings account from last 2 months.
  - If you are disabled or require dialysis / physical therapy on a regular basis, please submit a written doctor’s note verifying your disability.
  - Income for everyone living in the home must be submitted and not exceed the guidelines below. Please note that every individual who applies for the program must submit income information. (Income limits updated as of 5/10/21.)

  1-person HH $47,550
  2-person HH $54,350
  3-person HH $61,150
  4-person HH $67,900
  5-person HH $73,350
  6-person HH $78,800
  7-person HH $84,200
  8-person HH $89,650
B. Eligible Services

Transportation service is limited to a defined service territory and will be provided for the following purposes:

- Medical/Health care- hospital, doctors office, dental office, and other medical facilities.
- Essential Shopping – Grocery Store, Walgreens, CVS, Target, Walmart.
- Employment / College / Other Educational Training – trips can be utilized for employment, college and educational training, but should not be relied upon as the main means of transportation since trips are limited to 48 one-way trips per year.
- Other essential services – such as banks, credit unions, post office, library, spousal visits to medical or care facilities, any Public Service Agency such as local food pantry, or any local public service organization located in St. Charles County which helps the low-income and prevents homelessness, Social Security Office, or to purchase any medical device or medical equipment.
- Please note: Trips outside of St. Charles County / City for purposes other than medical are not eligible under this program. Any medical trip made outside of St. Charles County / City must be 15 miles from your home in order to be authorized.

C. Service Territory

- Transportation service will be provided within St. Charles County / City only. Any trip to St. Louis County will only be authorized if it is for a medical appointment and within 15 miles from your home.

The County asks that you shop locally whenever possible to support your hometown businesses and to keep tax dollars in your community.

D. Service Availability

Transportation services will be provided by OATS, Inc. @ 314-888-6720. Several modes of transportation are provided depending on need and ability. Transportation services are available to serve the needs of the disabled. Transportation must be scheduled by noon, 2 business days prior to the day transportation is needed.

- Ambulatory service is provided for healthy adults with the ability to walk to and from the vehicle and to sit during transportation. Assistance may be provided to and from the vehicle. Ambulatory transportation is provided Monday through Saturday from 6 a.m. to 6 p.m.
- Para lift service is available for wheelchair participants. Assistance is provided to and from the vehicle. Para lift service is available Monday through Saturday from 6 a.m. to 6 p.m.

OATS recognizes the following 9 holidays: New Year’s Day, Martin Luther King Jr. Day,
President’s Day, Memorial Day, 4th of July, Labor Day, Thanksgiving, Day after Thanksgiving & Christmas. If the Holiday falls on a Saturday the preceding Friday will be the day OATS observes the Holiday. If the Holiday falls on a Sunday the following Monday will be the day OATS observes the Holiday. Transportation on these holidays may be available but your trip account will be charged double for services on a Holiday.

E. Ineligible Services

- Transportation outside of the defined service territory unless pre-authorized for a specific medical purpose.

- Transportation to entertainment facilities such as casinos, restaurants, and bars.

- Transportation for someone other than the authorized rider. An individual may be accompanied by a companion; however, the transportation service must be for the benefit of the individual authorized for service.

- Transportation to the mall is not eligible.

F. Process

- All applications must be complete upon submittal in order to be eligible. Please sign all signature blocks throughout application and include all supporting documentation. Supporting documentation required is indicated with a check mark on the first page of these guidelines. If the supporting documentation is not included with your application, there will be a delay in processing.

- Each eligible member of a household may apply for the program. A separate application will be required for each member that applies.

- Please allow up to two weeks for a response on acceptance into the program.

- All participants to the program will receive an allocation of 48 one-way trips for their transportation needs for the period of January 1st - December 31st, 2022. Trips are monitored based on a calendar year. If you are a dialysis or chemotherapy patient, you will be allowed 96 one-way trips per year.

- Priority participation will be given to applicants with life sustaining medical needs. If the Transportation Program becomes limited, those with life sustaining medical needs will receive priority over others until additional funding becomes available.

*Additional trips may be available for those with life sustaining medical needs such as dialysis or chemotherapy based on available funding.

Questions regarding the Transportation Program can be directed to Maria Bryant @ 636-949-3213.

(Guidelines updated as of 12/27/21)
2022 ST. CHARLES URBAN COUNTY / CITY TRANSPORTATION PROGRAM
APPLICATION

PARTICIPANT INFORMATION

Applicant Name ____________________________________________________________

Address _______________________________________________ Zip Code __________

Phone: Home __________________________ Business/Cell _________________________

Email address __________________________

Are you a U.S. Citizen?   Yes _____  No _____

If not a U.S. Citizen, are you a Legalized Alien? Yes _____  No _____

Are you an Illegal Alien? Yes _____  No _____

Are you elderly? (62 or older) Yes _____  No _____ Are you Disabled? Yes _____  No _____

Are you a Veteran? Yes _____  No _____

Age of Applicant ________ Are you a dialysis patient? ________________________

Briefly describe the services that you require:

________________________________________________________________________

________________________________________________________________________

Please check the following that apply to your transportation needs:

I am ambulatory and require no assistance ______

I need assistance in and out of the vehicle ______

I need assistance from my door, in and out of the vehicle, and up to the door at my destination. ______

I use a cane ________ I use a walker ________

I use a wheelchair ________ if yes, do you weigh over 200 lbs.? ______

   Do you have a wheelchair ramp? ______

   Do you have outside steps from your front door ______ how many steps? ______

Page 1
I will use the transportation services primarily for:

- Medical (hospital, doctor office, dental office, or any other medical facilities)
- Essential shopping (Grocery store, pharmacy, CVS, Walgreens, Target, Walmart.)
- Dialysis or Chemotherapy (list location and how many times per week) __________

- Employment (address of employment, must be located in St. Charles County) ________

- College or Educational Training (must list the college or educational training location, must be located in St. Charles County). __________

- Public Service (must list Public Service Agency you are requesting and must be pre-approved in advance. Examples of allowed Public Service trips are: local food pantry, any local Public Service organization located in St. Charles County which helps the low income and prevents homelessness, local church. ________

Will anyone accompany you? ________
  If yes, how many persons? ________ Are they over the age of 18? ________

Do you currently drive? ________

Do you have access to a vehicle? ________

Do you have any unusual transportation needs? ________
  If yes, briefly explain: ____________________________________________________________
  ____________________________________________________________
Do you have any special medical conditions or disabilities that we should be aware of? ________

If yes, please explain: ________________________________________________________________

________________________________________________________________________________

Emergency Contact Information- MUST BE COMPLETED (family, friend, neighbor, etc.)

Whom may we contact in the event of an emergency:

Name: __________________________________________

Address: ______________________________________

________________________________________________________________________________

Phone: Home________________ Business________________ Cell________________

Relationship________________________________________

Are you an Elderly Female Head of Household (are you caring for children that reside in your home)?

Yes ______ No ______

When is the best time to contact you? ________________________________

Please mail, email, or fax your completed application and all supporting documentation to:

City of St. Charles
Community Development / Maria Bryant
200 North Second Street
St. Charles, MO  63301
636-949-3213
Fax: 636-949-3557
maria.bryant@stcharlescitymo.gov
DECLARATION

The undersigned acknowledge that participation in the St. Charles Urban County / City Transportation Program is voluntary.

The undersigned hereby apply for participation in the Transportation Program as administered by the City of St. Charles, on behalf of the St Charles Urban County and agree to provide the City with the information requested on the Participant Information Form, the Eligibility Certification and all other information requested by the City or County.

The undersigned further agree to comply with all program conditions, including, but not limited to, compliance with all applicable federal, state, county, and/or city requirements pursuant to the Housing and Community Development Act of 1974, as amended.

The undersigned hereby authorize the City to obtain the documents necessary for participation in the St. Charles Urban County / City Transportation Program, including title information, income verification, etc.

The undersigned affirm and acknowledge that any misrepresentation of material facts or the failure to produce any requested information may result in a declaration of non-eligibility or a termination of continued participation in the program and a consequent denial of any and all benefits.

The undersigned further represent and warrant that the information that has been given is true and complete to the best of their knowledge.

The undersigned further affirm and acknowledge that they have been notified of and understand their rights and responsibilities as applicants for the St. Charles Urban County / City Transportation Program.

I hereby certify that all the information stated herein, as well as any information provided in the accompaniment herewith, is true and accurate.

Warning: HUD will prosecute false claims and statements. Convictions may result in criminal and/or civil penalties. (18 U.S.C. 1001, 1010, 1012; 31 U.S.C. 3729, 3802)

RIDER ___________________________ DATE ___________________________

RIDER ___________________________ DATE ___________________________

CDBG SPECIALIST ___________________________ DATE ___________________________

Page 4
RELEASE

This release is made and entered into this _____ day of ________________, 20__, by and between ____________________________, hereinafter referred to as “Rider”, and St. Charles County (hereinafter referred to as the “County”).

In consideration of the Rider’s voluntary participation in the St. Charles Urban County/City Transportation Program, the Rider hereby releases and agrees to indemnify and hold harmless St. Charles County, the Cities of Cottleville, Lake St. Louis, New Melle, St. Peters, St. Paul, Weldon Spring, Wentzville, City of St. Charles, its agents, employees, and officers from all claims, damages or causes of action (including reasonable attorneys fees) caused by or arising in any manner from the Rider’s participation in the St. Charles Urban County/City Transportation Program and any agreements between the Rider and the transportation provider.

I, the Rider, have read this release and understand all its items. I execute it voluntarily and with full knowledge of its significance the day and year first written above.

______________________________  __________________________
RIDER  DATE

______________________________  __________________________
RIDER  DATE

Discrimination is prohibited on the basis of race, color, religion/creed, sex, handicap, familial status, national origin age, physical or mental disability, veteran status, genetic information, or citizenship.
ST. CHARLES URBAN COUNTY / CITY
TRANSPORTATION PROGRAM

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name:__________________________________________

Date of Birth:________________________________

1. I authorize the use or disclosure of the above-named individual’s health information as described below.

2. The following individual or organization is authorized to make the disclosure:

   St. Charles County Urban Transportation Program c/o City of St Charles
   Address: 200 N 2nd St, Ste 303, St. Charles, MO 63301

3. The type and amount of information to be used or disclosed is participant information provided with my application for the St. Charles Urban County Transportation Program relating to my transportation needs.

4. This information may be disclosed to and used by the following individual or organization:

   OATS, Inc. East Region
   Address: 186 Northwest Industrial Drive, Bridgeton Missouri 63044 for the purpose of: Transportation Services.

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the address noted above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Urban County Community Development Block Grant Administrative Office at 636-949-3213.

Signature of transportation participant or legal representative: ________________________ Date __________

If signed by legal representative, authority to act for transportation participant:

Signature of witness: ____________________________________________________________

HRS/HIPAA/Transportation Program Disclosure Form

Page 6
The County / City is required to provide statistical information to the U.S. Department of Housing and Urban Development on those participating in our program. Please check each category below that applies. There may be a delay in processing the application if the statistical questions are not completed.

<table>
<thead>
<tr>
<th>Racial Categories</th>
<th>Total Number of Race Responses</th>
<th>Total Number of Hispanic or Latino Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian or Alaska Native</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black or African American</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Indian or Alaska Native and White</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian and White</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black or African American and White</td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Indian or Alaska Native and Black or African American</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Other multiple race combinations greater than one percent: [Per the form instructions, write in a description using the box on the right]

Balance of individuals reporting more than one race

Total:

* If the aggregate count of any reported multiple race combination that is not listed above exceeds 1% of the total population being reported, you should separately indicate the combination. See detailed instructions under “Other multiple race combinations.”

Public reporting burden for this collection is estimated to average 1.15 hours per response, including the time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the information collection instrument. HUD may not collect this information, and you are not required to complete this form unless it displays a currently valid OMB control number.
**ST. CHARLES URBAN COUNTY AND CITY TRANSPORTATION PROGRAM ELIGIBILITY CERTIFICATION**

**PLEASE NOTE:** THIS FORM MUST BE COMPLETED FOR DETERMINING INCOME LEVEL REGARDLESS OF AGE OR DISABILITY

Please be sure to include proof of income for everything listed below along with 2021 Federal Taxes for everyone living in the home.

---

I did not file **2021** Federal Income Taxes and I understand I must show proof of all income listed below*

*only check this if you were not required to file Federal Taxes and then sign below

---

**SOURCE OF INCOME**

<table>
<thead>
<tr>
<th>Wages or Salary from Employment. Enter Name of Employer(s):</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Earnings from Self-Employment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security</td>
<td></td>
</tr>
<tr>
<td>Veteran's Benefits</td>
<td></td>
</tr>
<tr>
<td>Pensions/Annuities</td>
<td></td>
</tr>
<tr>
<td>Dividends or Interest</td>
<td></td>
</tr>
<tr>
<td>Unemployment Compensation</td>
<td></td>
</tr>
<tr>
<td>401 (k) Retirement Plan</td>
<td></td>
</tr>
<tr>
<td>Worker's Compensation</td>
<td></td>
</tr>
<tr>
<td>Savings and Checking Statements</td>
<td></td>
</tr>
<tr>
<td>Maintenance/Alimony</td>
<td></td>
</tr>
<tr>
<td>Income from Rental Property</td>
<td></td>
</tr>
<tr>
<td>Supplemental Security Income (SSI)</td>
<td></td>
</tr>
<tr>
<td>TANF</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Types of Income. List:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**2021**

<table>
<thead>
<tr>
<th>GROSS INCOME</th>
<th>PERSON(S) RECEIVING INCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TOTAL GROSS INCOME FOR <strong>2021</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TOTAL HOUSEHOLD MEMBERS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I hereby certify that all the information stated herein, as well as any information provided in the accompaniment herewith, is true and accurate.

Warning: HUD will prosecute false claims and statements. Convictions may result in criminal and/or civil penalties. (18 U.S.C. 1001, 1010, 1012; 31 U.S.C. 3729, 3802)

Signature

---

Page 8
Part I: Confidential Participant / Beneficiary HUD Demographic Information
(This section is voluntary)

<table>
<thead>
<tr>
<th>Ethnicity (Select One)</th>
<th>□ Not Hispanic</th>
<th>□ Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black/African American</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nat. Hawaiian/Other Pacific Isl.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Am. Indian/Alaskan Nat. &amp; White</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian &amp; White</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black/African American &amp; White</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Am. Indian/Alaskan &amp; Black/African</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Multi-Racial</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Part II: Confidential Participant / Beneficiary Income Certification
(Must be completed and signed prior to providing public service)

My total family size consists of __________ members, and the total gross annual income* for all adult members is $__________

*Gross annual income must include all sources of income (wages, child support, SSI, unemployment, pension, income from assets, etc., but does not include the income of live-in aids, per 24 CFR 5.403)

I certify that the information given on this form is true and accurate to the best of my knowledge. I am aware that there are penalties for willfully and knowingly giving false information on an application for Federal or State funds, which may include immediate repayment of all Federal or State funds received and/or prosecution under the law. I understand that the information on this form is subject to verification by state or federal personnel as part of compliance monitoring.

Participant / Beneficiary Information:
Signature: ________________________________ Date: ________________
Name (print): ____________________________
Physical Home Address: ______________________(City)__________