

ST. CHARLES URBAN COUNTY / ST. CHARLES CITY
TRANSPORTATION PROGRAM
2020

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, 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, 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 2020 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 is as follows:
 - ✓ Please submit a copy of your identification (old driver's license, Missouri identification card).
 - ✓ Please submit proof of all income you receive monthly, quarterly or yearly along with your 2019 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 5/3/19.)

1-person HH \$45,550
2-person HH \$52,050
3-person HH \$58,550
4-person HH \$65,050
5-person HH \$70,300
6-person HH \$75,500
7-person HH \$80,700
8-person HH \$85,900

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. 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.
- Each eligible member of a household may apply for the program.
- Please allow up to two weeks for a response on acceptance into the program.
- All participants to the program will receive an allocation of up to 48 trips for their transportation needs for the period of January 1st - December 31th, 2020. Trips are monitored based on a calendar 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 12/26/19)

ST. CHARLES URBAN COUNTY / CITY
2020 TRANSPORTATION PROGRAM 636-949-3213

PARTICIPANT INFORMATION

Applicant Name _____

Address _____ Zip Code _____

Phone: Home _____ Business/Cell _____

Is anyone else living in your home also applying for the program? _____

If yes, please list name _____

Please briefly describe the services that you require:

Please complete the following:

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? _____

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 a Veteran? Yes _____ No _____

Are you an Elderly Female Head of Household (are you caring for children that reside in your home)?
Yes _____ No _____

How did you learn about the program? _____

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

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.

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

**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:

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 **2019 Federal Taxes** for everyone living in the home.

I did not file **2019** 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

<u>Office Use Only</u>	<u>SOURCE OF INCOME</u>	2019 <u>GROSS INCOME</u>	<u>PERSON(S) RECEIVING INCOME</u>
	Wages or Salary from Employment. Enter Name of Employer(s):	\$ _____	_____
	_____	\$ _____	_____
	_____	\$ _____	_____
	_____	\$ _____	_____
	Earnings from Self-Employment	\$ _____	_____
	Social Security	\$ _____	_____
	Veteran's Benefits	\$ _____	_____
	Pensions/Annuities	\$ _____	_____
	Dividends or Interest	\$ _____	_____
	Unemployment Compensation	\$ _____	_____
	Railroad Retirement	\$ _____	_____
	Worker's Compensation	\$ _____	_____
	Savings and Checking Statements	\$ _____	_____
	Maintenance/Alimony	\$ _____	_____
	Income from Rental Property	\$ _____	_____
	Supplemental Security Income (SSI)	\$ _____	_____
	TANF	\$ _____	_____
	Other Types of Income. List:	\$ _____	_____
	_____	\$ _____	_____
	_____	\$ _____	_____
	TOTAL GROSS INCOME FOR 2019	\$ _____	_____
	TOTAL HOUSEHOLD MEMBERS	_____	_____

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

Public Service Program SELF-CERTIFICATION of Income for

City of / Town of / County of _____ **CDBG Funded Activity**

Name of Public Service: _____

Page 1 to be filled out by Participant

Part I: Confidential Participant / Beneficiary HUD Demographic Information

(This section is voluntary.)

Ethnicity (Select One)	<input type="checkbox"/> Not Hispanic	<input type="checkbox"/> Hispanic
Race	(Select One)	
White	<input type="checkbox"/>	
Black/African American	<input type="checkbox"/>	
Asian	<input type="checkbox"/>	
American Indian/Alaskan Native	<input type="checkbox"/>	
Nat. Hawaiian/Other Pacific Isl.	<input type="checkbox"/>	
Am. Indian/Alaskan Nat. & White	<input type="checkbox"/>	
Asian & White	<input type="checkbox"/>	
Black/African American & White	<input type="checkbox"/>	
Am. Indian/Alaskan & Black/African	<input type="checkbox"/>	
Other Multi-Racial	<input type="checkbox"/>	

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) _____

U.S. Department of Housing and Urban Development
 Community Planning and Development
 Community Development Block Grant (CDBG)

SELF CERTIFICATION OF ANNUAL INCOME BY BENEFICIARY

Printed on:

Effective Date:

INSTRUCTIONS: This is a written statement from the beneficiary documenting the definition used to determine "Annual (Gross) Income", the number of beneficiary members in the family or household (as applicable based on the activity), and the relevant characteristics of each member for the purposes of income determination. To complete this statement, select the definition of income used, fill in the blank fields below, and check only the boxes that apply to each member. Adult beneficiary members must then sign this statement to certify that the information is complete and accurate, and that source documentation will be provided upon request.

Definition of Income

<input type="radio"/> HUD 24 CFR Part 5	<input type="radio"/> IRS Form 1040	<input type="radio"/> American Community Survey
---	-------------------------------------	---

Beneficiary Information

Last Name:	Beneficiary ID (if applicable):
------------	---------------------------------

Member Information

First Names:	Member IDs (if applicable):	HH	CH	DIS	62+	S≥18	<18	<15
	1							
	2							
	3							
	4							
	5							
	6							

HH = Head of Household; CH = Co-Head of Household; DIS = Person with disabilities; 62+ = Person 62 years of age or older; S≥18 = Fulltime student age 18 or over; <18 = Child under the age of 18 years; <15 = Minor under the age of 15 years

Contact Information

Address Line 1:	City:
Address Line 2:	State: Zip Code:

Income Information

Annual gross income (total of all members) = \$ _____

Certification

I/we certify that this information is complete and accurate. I/we agree to provide, upon request, documentation on all income sources to the HUD Grantee/Program Administrator.

COMPLETE SIGNATURES ON SECOND PAGE

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.

Race and Ethnic Data Reporting Form

U.S. Department of Housing and Urban Development
Office of Strategic Planning
Grants Management and Oversight Division

OMB Approval No. 2535-0113
(exp. 06/30/2017)

Program Title: _____

Grantee/Recipient Name: _____

Grantee Reporting Organization: _____

Reporting Period From (mm/dd/yyyy): _____ To (mm/dd/yyyy): _____

Racial Categories	Total Number of Race Responses	Total Number of Hispanic or Latino Responses
American Indian or Alaska Native		
Asian		
Black or African American		
Native Hawaiian or Other Pacific Islander		
White		
American Indian or Alaska Native <i>and</i> White		
Asian <i>and</i> White		
Black or African American <i>and</i> White		
American Indian or Alaska Native <i>and</i> Black or African American		
* 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.

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

Male _____ Female _____

Age of Applicant: _____

Are you a dialysis patient? _____

Are you disabled based on the HUD Section 504 regulation?

Yes _____ No _____

Are you a Veteran? Yes _____ No _____

How did you learn about the St. Charles County / City Urban Transportation Program?
