PENQUIS

Helping Today • Building Tomorrow

Lynx Mobility Services
PO Box 1162
Bangor, ME 04402-1162

DHHS LOW INCOME TRANSPORTATION PROGRAM

Dear Customer:

If you need help with transportation, please fill out the DHHS Low Income Transportation application. We will need to have proof of all sources of income for each person in the home. Here is a list of some items you can send in for proof of income:

- Paystubs
- Letter from DHHS showing the amount you receive in food stamps
- Proof of General Assistance
- Letter from Social Security showing the amount you receive
- Bank statement

If you are over the income limit for this program we can subtract medical costs from your income. The only items we can subtract from your income are what you pay for:

- Prescriptions
- Health insurance
- Medical bills

We will need to have proof of any medical costs you want to use. If you need help with this application, please call Lynx at 973-3695. Thank you.

Sincerely,

Lynx Mobility Services

Updated 07/26/16

262 Harlow Street
PO Box 1162
Bangor, Maine 04402
www.penquis.org

(207) 973-3500
Fax (207) 973-3699
TDD (207) 973-3520
1-800-215-4942

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DHHS LOW INCOME TRANSPORTATION
TRANSPORTATION SERVICE CENTER
PO BOX 1162
BANGOR ME 04402-1162
973-3695

Household Size	Yearly Income	Monthly Income
1	$24,280.00	$2,023.33
2	$32,920.00	$2,743.33
3	$41,560.00	$3,463.33
4	$50,200.00	$4,183.33
5	$58,840.00	$4,903.33
6	$67,480.00	$5,623.33
7	$76,120.00	$6,343.33
8	$84,760.00	$7,063.33
For Each Additional Person, Add	$8,640.00	$720.00

PENQUIS LYNX TRANSPORTATION – DHHS LOW INCOME TRANSPORTATION PROGRAM

I hereby apply for transportation services at Penquis Lynx Transportation of Bangor. (Reimbursement Bus Tickets Rides)

Applicant's Name: _____ Date of Birth: _____

Address: _____ Town or City: _____ Zip Code: _____

Telephone No.: _____ Social Security No.: _____ MaineCare No.: _____

The following information is collected for purposes of planning, evaluation and research only. This information may not be used to reduce or deny services to you.

Employment Status: _____(Employed part-time, full-time, unemployed)

Occupation: _____ Sex: _____

Ethnicity (Race, National Origin): _____ Marital Status: _____

LIVING ARRANGEMENTS: I live:

- ☐ Alone in my own home or apartment
- ☐ With one parent
- ☐ With both my parents
- ☐ With my spouse, and children, if any
- ☐ With relatives
- ☐ With non-relatives
- ☐ In an institution or residential center
- ☐ In an adult boarding home
- ☐ In a licensed foster home for children
- ☐ In an approved foster home for adults
- ☐ In a children's group home
- ☐ At a boarding school
- ☐ In an adoptive home
- ☐ In a maternity home
- ☐ In a correctional facility
- ☐ In a hospital
- ☐ In a nursing home
- ☐ In the military services
- ☐ Other:

MEMBERS OF MY HOUSEHOLD INCLUDE:

	Name	Relationship to Me	Sex	Date of Birth
1				
2				
3				
4				
5				
6				

INCOME AND SOURCE: The following information is needed to determine your eligibility for service. Services funded by Title XX or other funds administered to the Bureau of Resource Development are free to eligible clients except for day care services and some Mental Retardation Services for which a fee is charged for those earning more than 60% median income.

- ☐ TANF (Temp. Assist. To Needy Families) $ _____
- ☐ SSI (Supplementary Security Income) $ _____
- ☐ Social Security $ _____
- ☐ Veterans Pension $ _____
- ☐ General Assistance $ _____
- ☐ Employ. Wages/Salary before Deductions $ _____
- ☐ Dividends/Interest $ _____
- ☐ Unemployment Compensation $ _____
- ☐ Net Income from Self Employment $ _____
- ☐ Rental Income $ _____
- ☐ Retirement Pension $ _____
- ☐ Child Support/Alimony $ _____
- ☐ Other (Specify) $ _____
- ☐ Other (Specify) $ _____

The number of people in my household sharing the income listed above is: _____. The total income is: _____

Deductible Medical Expenses: _____ Adjusted Income (income minus medical expenses): _____

Deductible medical expenses are out of pocket costs and can be used to bring down your income if you are over the income guidelines. Proof of all income and any medical expenses you wish to use need to be turned in with the application for processing.

I certify under penalty of perjury that to the best of my knowledge the above information is correct. If there is any change in my income or living arrangement I will notify the agency which is providing me this service at once. I understand that this information will be provided to the central office of the Department of Health and Human Services for use in administration of this program.

_____ _____

Signed Date

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Release of Information/Lynx Mobility Services
Return this form to:

Penquis, P O Box 1162, Bangor, ME 04402-1162

Permission to get records

I, _____ give permission for Penquis to speak with medical/other providers to confirm Lynx covered services. Penquis will help me make new appointments, if need be.

I understand that:

- **I can cancel this release at any time.**
- **This information is needed to provide rides or pay mileage for my Lynx covered services.**
- **Penquis will not provide services without this information.**
- **This form is good for 1 year from the date I sign it.**
- **I have received the informational forms needed to get help with transportation.**
- **No other transportation is available to me and my family. I will let Penquis know if the situation changes.**
- **I understand that Penquis has the duty to arrange the least costly means of transportation that is suited to each persons need.**
- **This data is true and complete. Payment of this claim will be from Federal/State funds. Any lie or false data of a material fact may be subject to legal action under Federal/State laws.**

Signature 1:_____ Date _____

IMPORTANT INFORMATION FOR ALL DEPARTMENT OF HEALTH HUMAN SERVICES CLIENTS REGARDING SOCIAL SERVICES PROVIDED DIRECTLY BY THE DEPARTMENT OR THROUGH PUBLIC SOCIAL SERVICES PROVIDED DIRECTLY BY THE DEPARTMENT OR THROUGH PUBLIC OR PRIVATE COMMUNTIY AGENCIES WHICH PROVIDE SERVICE UNDER CONTRACT TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

HEARING RIGHTS

If you are not satisfied with a decision made regarding your eligibility for or the provision of social services, you have the right to ask for a hearing before the Commissioner of the Department of Health and Human Services or his agent.

If you want an informal conference with the Regional Director or Director of the Provider Agency or his agent, you should request it within ten (10) days of the notice of the action by contacting the office where you made application for or received the service.

If you want a formal hearing, you must request it by contacting the same office or the Commissioner of the Department of Health and Human Services, State House Station #11, Augusta, Maine 04333. A request for a formal hearing must be made within thirty (30) days of the effective date of the notice of the action you wish to appeal.

If you request either type of hearing within ten (10) days of the date of the notice regarding your eligibility for or the provision of social services, the proposed action will not go into effect until your appeal has been heard and a decision rendered.

CIVIL RIGHTS NOTICE

If you feel you have been discriminated against because of your race, color or national origin, you may file a complaint requesting a hearing on this matter with a Regional or the State Office of the Department of Health and Human Services or with U.S. Department of Health, Education and Welfare, Washington, D.C.

REPORTING RESPONSIBILITIES

REMEMBER! It is your responsibility to report to the agency providing the social service to you all changes in your circumstances which could affect your eligibility for the services. Should you receive benefits to which you are not entitled due to failure to report changes promptly and correctly, you will be expected to repay any benefits for which you were not eligible.

FRAUDULENT REPRESENTATION

The willing acceptance and/or use of any State and/or Federal funds under this program for which a person knowingly is not eligible may constitute fraud and subject the user to prosecution under penalties of law.

FOR FURTHER INFORMATION ABOUT ANY OF THE ABOVE, CALL OR WRITE THE AGENCY NAMED ON THE REVERSE SIDE OF THIS NOTICE

7/26/2016