APPLICATION FOR OSCAR
SENIOR TRANSPORTATION PROGRAM

The Onondaga County Department of Adult and Long Term Care Services and Centro sponsor a ride service for senior citizens who reside in Onondaga County. The Onondaga Senior Call-A-Ride Service (OSCAR) is **NOT Call-A-Bus service; eligibility is based on age only**. Voluntary contributions are accepted and used to expand services. The OSCAR suggested contribution is $2.00 per trip. However, a contribution in any amount is welcomed. No one will be denied services if unable or unwilling to contribute. Please let the transportation coordinator know if you are making a contribution when scheduling your ride.

OSCAR Requirements:

- **Must be at least 60 years old and reside in Onondaga County**.
- Services offered to locations outside the Call-A-Bus service area and within Onondaga County.
- A maximum of two (2) round trips or four (4) one-ways per month. (This is subject to change depending on funding.)
- Service operates Monday through Friday from 7:00am to 7:00pm. This service is not available on weekends and holidays.
- Reservations are accepted 14 days in advance, but no less than 2 business days, of the desired travel date.
- The OSCAR service **cannot** be used for medical transportation if the customer is eligible for Medicaid. Please contact your Medicaid worker for assistance to medical appointments.
- For more information, regarding this program, please call 442-3434 Monday through Friday from 8:00am to 5:00pm.

Complete all parts of this application and send to:
OSCAR Senior Transportation
200 Cortland Ave., P.O. Box 820
Syracuse, NY 13205-0820

Please keep cover page for future reference.

Page left blank intentionally.

Department of Adult and Long Term Care – Registration Form

PLEASE PRINT NEATLY

DATE REGISTERING: _____ PROVIDER: _____OSCAR_____

FIRST NAME: _____ MI: _____ LAST NAME: _____

MARITAL STATUS: _____ GENDER: _____ BIRTH DATE: _____

(Married, Divorced, Separated, Lifetime Partner, Widowed, Single-Never Married)

SOCIAL SECURITY NO. (Last 4 digits): _____ PHONE NUMBER: _____

ADDRESS: _____

CITY: _____ COUNTY: _____

STATE: _____ ZIP CODE: _____

ETHNIC RACE:
- ❑ American Indian / Native Alaskan
- ❑ Asian
- ❑ Black / African American
- ❑ Hispanic – White
- ❑ Native Hawaiian / Other Pacific Islander
- ❑ White (Non-Minority / Non-Hispanic)
- ❑ Other

ETHNICITY:
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino

Single income below $990 / Month:	❑ YES	❑ NO
Couple income below $1335 / Month:	❑ YES	❑ NO
Do you participate in Medicaid:	❑ YES	❑ NO
Live alone:	❑ YES	❑ NO
Disabled:	❑ YES	❑ NO
Frail:	❑ YES	❑ NO
Understands English:	❑ YES	❑ NO
Veteran:	❑ YES	❑ NO
Veteran Dependent:	❑ YES	❑ NO
Is English your primary language:	❑ YES	❑ NO
Is it difficult for you to read, speak, write or understand English:	❑ YES	❑ NO
Do you need a translator:	❑ YES	❑ NO
Are you a refugee:	❑ YES	❑ NO

If yes, what Country: _____

Can you travel without the assistance of another person: ❑ YES ❑ NO

Can you climb three 12 inch steps without assistance: ❑ YES ❑ NO

When you are traveling, do you use: (please check)

❑ CANE
❑ WALKER
❑ WHITE CANE
❑ SERVICE ANIMAL
❑ WHEELCHAIR
❑ POWER WHEELCHAIR
❑ SCOOTER

I, the undersigned applicant, do hereby state that the information contained in this application is true and complete to the best of my knowledge.

SIGNATURE: _____

DATE: _____

If someone other than the applicant completed this form on behalf of the applicant, that person must complete the following:

NAME: _____

RELATIONSHIP: _____

ADDRESS: _____

SIGNATURE: _____

DATE: _____

Informed Consent Form
(Aging Services)

Client must initial each section that applies and sign at the end. Worker must complete attestation.

Informed Consent to Collect and Record Personal Information

I consent to the Onondaga County Department of Adult & Long Term Care Services saving personal information provided by me or my authorized representative in the Client Data System maintained by the New York State Office for the Aging (NYSOFA). Saving my information like this allows other agencies that use the Client Data System to see my information if a referral is made, but this will only happen with my permission.

I understand that this information is being collected to help in providing services under the NYSOFA and local Offices for the Aging. It also helps to identify other services that I may need. I understand that this information is needed in order for some services to be provided. The authority to provide these services and to collect my information for these purposes is found in the Older Americans Act and the New York State Elder Law.

I understand that, per New York State's Personal Privacy Protection Law, my personal information will be kept confidential. It will not be shared without my permission.

I understand what information will be recorded, the need for the information, and that there are laws and regulations protecting my information.

I understand that signing this authorization is voluntary, but that refusal to do so may limit options available to me.

Client Initial _____

Informed Consent to Refer and Share Personal Information

I request and consent to the release by Onondaga County Department of Adult & Long Term Care Services of all requested records, including but not limited to, personal information, health information, and any other information concerning me that I have provided to Onondaga County Department of Adult & Long Term Care Services to the following entities so they can make referrals for services that I may need, or for the purposes identified as follows:

_____
_____
_____
_____

I understand what information will be released, the need for the information and that there are laws and regulations protecting the confidentiality of this information.

I understand that signing this authorization is voluntary, but that refusal to do so may limit options available to me.

I understand that information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and in such an event may no longer be protected by federal or state law.

Client Initial _____

Informed Consent to Share Certain Information in the event of a Disaster or Emergency

In the event of a disaster or emergency, I consent to the release of information about services I receive, my housing situation and who I live with, medical equipment or services needed daily, prescription medications taken daily, special dietary needs, special communication needs, blindness or other visual impairments, and information about my general condition and mobility.

I understand that this information will only be given to those who will use it to respond to an emergency, such as government agencies, law enforcement, or those acting on their behalf if there is a disaster or emergency situation.

I understand that information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and in such an event may no longer be protected by federal or state law.

Client Initial _____

I consent to actions above where I have initialed. The authorizations provided shall not expire unless revoked.

_____
Date

_____
Signature of individual or legal representative

_____
Individual's name (Print)

_____
If legal representative, provide name and relationship to individual