



**Regional Transportation Program, Inc  
Application For Transportation Services**

The State of Maine, DHS Community Services Center **requires** clients to fill out an application to receive transportation services under their contract. This application **must** be filled out correctly and returned to RTP **before** transportation is arranged.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Social Security No. \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_, ME ZIP \_\_\_\_\_ Tel No \_\_\_\_\_

Mailing Address, if different \_\_\_\_\_

Do you receive MaineCare? \_\_\_\_\_ if yes, number \_\_\_\_\_

**Income and Source – Please check and fill out all that apply.**

The following information is needed to determine your eligibility for service. Copies of income verification **must** be attached to this application. If not, your application will be returned. Please see reverse page for income verification requirements.

- |                                                            |                    |                                                   |                    |
|------------------------------------------------------------|--------------------|---------------------------------------------------|--------------------|
| <input type="checkbox"/> TANF                              | Amt \$ _____ month | <input type="checkbox"/> Dividends / Interest     | Amt \$ _____ month |
| <input type="checkbox"/> SSI                               | Amt \$ _____ month | <input type="checkbox"/> Unemployment Comp        | Amt \$ _____ month |
| <input type="checkbox"/> Social Security                   | Amt \$ _____ month | <input type="checkbox"/> Rental Income            | Amt \$ _____ month |
| <input type="checkbox"/> Veterans Pension                  | Amt \$ _____ month | <input type="checkbox"/> Retirement Pension       | Amt \$ _____ month |
| <input type="checkbox"/> General Assistance                | Amt \$ _____ month | <input type="checkbox"/> Child Support            | Amt \$ _____ month |
| <input type="checkbox"/> Employment Wages<br>(gross wages) | Amt \$ _____ month | <input type="checkbox"/> Other (specify)<br>_____ | Amt \$ _____ month |

Total Monthly Income \_\_\_\_\_ Number of people in household \_\_\_\_\_

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 service at once. I understand this information will be provided to the central office of the Department of Human Services for use in administration of this program.

\_\_\_\_\_  
Signature Date

**Important Information on Reverse Side**

**Regional Transportation Program, Inc  
Application for Transportation Services**

**Additional Information**

Income verification (Required information to be attached to application)

**Wages**            4 current and consecutive pay stubs

**Unemployment Compensation**        One month's worth of pays stubs

**TANF, SSI, Social Security, Veterans Pension, General Assistance, Dividends/Interest, Rental Income, Retirement Pension, Child Support / Alimony, Other Income**        Copy of check(s), check stub(s), or bank statement showing direct deposit. One month's worth of verification required.

---

Please mail this application along with the necessary income verification to:

Regional Transportation Program, Inc  
Transportation Application  
127 Saint John Street  
Portland, ME 04102

Or.....

Bring it into our office between the following hours

Monday through Thursday            8:00am to 4:00pm

Friday                                        8:00am to 12:00pm

---

**HEARING RIGHTS**

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

If you want an informal conference with the Regional Director or 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 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 (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 Human Services or with the 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.