BRIDGEWATER
Cares Transit

Application for Determination of Eligibility

The information obtained in this certification process will only be used by the Bridgewater Council on Aging for the provision of the Bridgewater Cares Transit service. Information will be shared only with other transit providers to facilitate your travel in their operating areas. This information will not be provided to any other person or agency other than those individuals or agencies involved in this certification process. Eligible applicants include:

- *Age 65+*
- *Age 65+ and disabled*
- *Disabled under age 65*
- *BSU Student*

PLEASE TYPE OR PRINT

Name:_____

Address:_____

Email: _____

Cell #:_____Home #:_____

Date of Birth:_____ BSU Student: _____yes _____no

PLEASE CHECK ALL THAT MAY APPLY

Mobility accommodations:

- ☐ I use a mobility aid:
  - ☐ Walker/Cane
  - ☐ Wheelchair
    - ☐ Manual
    - ☐ Electric Scooter
  - ☐ Crutches
- ☐ I ride with my PCA
- ☐ Other Accommodations we should know about: _____

Support programs I am enrolled in:

- ☐ DTA
- ☐ SNAP
- ☐ LIHEAP
- ☐ MassHealth
- ☐ MA Health Connector
- ☐ Public Housing Assistance
- ☐ TAFDC
- ☐ WIC
- ☐ ILC
- ☐ Youth Pass

Currently, do you use:

- ☐ Brockton Area Transit Dial-A-BAT
- ☐ COA Van
- ☐ BSU paratransit
- ☐ Taxi/Uber/Lyft
- ☐ Other

In order for the Bridgewater Cares Transit authority to properly evaluate your application, it may be necessary to contact your physician or other professional to confirm the information that you have provided. Please complete the following for informational and authorization purposes.

- ☐ Physician
- ☐ Health Care Professional
- ☐ Rehabilitation Professional

They are familiar with my disability and are authorized to provide the following information to the Bridgewater Cares Transit authority required to complete this certification.

Physician/Healthcare Professional

Name:_____

Phone #: _____

Address:_____

I certify that the information containing this application is true and correct to the best of my knowledge. Knowingly furnishing misleading information could result in denial of services.*

Applicant's Signature:_______

*If this application has been completed by someone other than the person applying for eligibility, the person must complete the following:

Name:_____

Address:_____

City:_____Zip Code:_____

Home Phone:_____Cell Phone: _____

Signature: _____