COLONIE SENIOR Service Centers, Inc.

Transportation Services

6 Winners Circle, Albany, NY 12205
518.459.6064

Colonie Senior Services, Inc. is required to have all riders using transportation services to register on an annual basis. This program is supported by Albany County Department for Aging, ACCESS and The Town of Colonie. Please note that you will not be able to schedule a ride prior to us receiving these completed forms back. Once we are in receipt of your packet, it can take seven (7) days to be added to the system and approved. Please return the completed forms in the enclosed self-addressed envelope to:

Colonie Senior Service Centers
Attn: Transportation Department
6 Winners Circle
Albany, NY 12205

If you are applying for Wheelchair Service, you must have your physician complete and sign Section A before returning your packet.

If you have any further questions, please don't hesitate to contact the Transportation Department at: (518) 459-6064. We will be happy to assist you.

525 East Street 4th Floor
Rensselaer, NY 12144
accesstransit@cdta.org
TEL-518-437-5161 FAX 518-453-8833

Access Transit Registration Form

ACCESS Transit brokers trips for Albany County residents aged 60 and over. Services are limited to seniors who have NO other means of transportation. Please fill out the entire form to be considered for registration. Clients that live within a quarter mile of a bus stop may be eligible for a CDTA *Navigator* Card for their transportation needs. Only clients with a disability that prohibits them from using public transit will qualify for services with ACCESS Transit.

☐ New Client ☐ Renew

Personal Information

Full Name: _____ Date of Birth: ___ / ___ / ____ Age_____

Last 4 digits of social security number: _____

Phone Number: (____) ____ - _____ Cell Number: (____) _____- _____Email _____

Home Address:_____City: _____ State: _____ Zip Code:_____

Medical Insurance Information

Insurance Provider Name: _____

Insurance ID Number: _____

Medicare Number: _____Medicaid Number: _____

If you have Medicaid, please contact Medicaid Transportation at: 1 (855) 360-3549. They will be able to assist with your medical transportation needs.

Ethnicity (optional):

☐ White/Caucasian
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Black
☐ Native American
☐ Asian
☐ Prefer not to say
☐ Other: _____

Are You:

☐ Single
☐ Married
☐ Widowed
☐ Divorced
☐ Separated

☐ Male
☐ Female

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Do you Live Alone? Yes No

If no, who do you live with? _____

Do you use any of the following mobility aids?

☐ Walker ☐ Wheelchair ☐ Scooter ☐ Cane ☐ None

Are you: ☐ Hearing Impaired ☐ Visually Impaired

Do you consider yourself disabled or frail? Please circle YES or NO.

Please indicate all physical challenges that may apply. _____

_____

Transportation Eligibility

Please answer the following questions truthfully to determine eligibility.

1. **Do you currently drive or have access to a personal vehicle?**

☐ Yes ☐ No

2. **Do you have any family, friends, or caregivers who can transport you to medical appointments?**

☐ Yes ☐ No

3. **Do you currently use public transportation (CDTA Buses or STAR)?**

☐ Yes ☐ No

4. **If yes, what type of public transportation do you use?**

_____

5. **Have you used other transportation services (such as Medicaid transport)?**

☐ Yes ☐ No

If yes, please explain: _____

6. **How do you currently get to your appointments?**

_____

7. **Are you a Veteran?**

☐ Yes ☐ No

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8. **Is there anything else we need to be aware of regarding your situation? Please be specific.**

Emergency Contact

Name: _____

Relationship: _____

Phone Number: (____) ____ - _____

Emergency Contact

Name: _____

Relationship: _____

Phone Number: (____) ____ - _____

Signature & Acknowledgement

By signing below, I certify that the information provided is accurate and truthful. I understand that this service is limited and based on need and availability.

Signature: _____ Date: ___ / ___ / _____

Town of Colonie Program & Services Registration Form

**** Must be Town of Colonie resident to utilize funding****

Date: _____ ☐ **New Registration** ☐ **Renewal** (update info as needed)

First Name	Middle Initial	Last Name	
Street Address			Apt. No.
City	State	Zip Code	Date of Birth
Home Phone	Cell Phone		

Bright Horizons Participant? ☐ Yes ☐ No **Location:** ☐ Beltrone ☐ Latham (KT II)

Program Selection: ☐ Transportation ☐ Senior Dining ☐ Both (answer appropriate questions below)

Transportation Purpose: Select all that apply ☐ Adult Day Program ☐ Medical ☐ Pharmacy ☐ Recreational/Social ☐ Nutrition (congregate dining sites) ☐ Grocery Shopping (vital) ☐ Personal

Congregate Dining Location: ☐ The Beltrone Living Center ☐ King Thiel Senior Community ☐ King Thiel II ☐ Bishop Broderick Apartments ☐ Sheehy Manor ☐ Guilderland Town Hall

Town of Colonie Authorization for Release of Information – new registrations only

I, _____ do authorize **Colonie Senior Service Centers, Inc.** to exchange information with the below named agency. The purpose of exchanging information is to utilize funding sources to help defray my cost or giving permission to speak with someone other than myself.

I understand and have been informed that information can be shared only with the agency listed here. If I should have any questions regarding the need for this information, I can contact the agency directly.

Town of Colonie Senior Resources Dept.
12 Metro Park Road, Ste. #103
Albany, NY 12205
518-459-5051

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 this consent will expire in one year from date this form is signed by me.

_____ _____

Signature of Individual or Legal Representative *Date*

_____ _____

Individual's Name (Print) *Legal Representative Name & Relationship*

CSSC Staff Attestation – I attest that informed consent was obtained from the above individual, who signed above.
****Staff can complete form and sign above for all renewal registrations. ****

_____ _____

Staff Signature *Date*

COLONIE SENIOR Service Centers, Inc.

Transportation
Authorization for Release of Information

I, _____ do authorize Colonie Senior Service Centers, Inc., to exchange information with the below named person/agencies. The purpose of exchanging information could include helping to locate funding sources to help defray my cost or giving permission to speak with someone other than myself.

I understand and have been informed that information can be shared only with the person/agencies named or identified on this release. I also understand that that any disclosure to a third person can lead to unauthorized further disclosures by that person or agencies which may not be subject to federal or state confidentially laws.

This consent will expire in one year unless specified below. My questions about this form have been answered and I know that I do not have to allow release of my information. I further understand that I may withdraw my consent to the release agreement at any time.

Name:	Albany County	Phone:	518-447-7198
Address:	Department for Aging	Fax:	518-447-7188
	100 Heritage Lane Albany, NY 12211	Email:	
Purpose:	HIPAA Compliance	Expiration:	

Name:	Access Transit Services	Phone:	518-437-5161
Address:	Rensselaer Railroad Station	Fax:	
	525 East Street Rensselaer, NY 12144	E-mail:	
Purpose:	HIPAA Compliance	Expiration:	

Name:	Town of Colonie	Phone:	518-783-2734
Address:	534 New Loudon Road	Fax:	
	Latham, NY 12110	E-mail:	
Purpose:	HIPAA Compliance	Expiration:	

Signature _____ **Date** _____
(Responsible Party)

Relationship if other than Participant _____

COLONIE SENIOR Service Centers, Inc.

Transportation Confidentiality Policy

The staff of Colonie Senior Service Centers understands that because of the services provided, it is necessary to treat any information pertaining to our clients as strictly confidential.

All agency personnel (paid or unpaid) are ethically bound to keep personal and program-related information about clients within the confines of the agency. This type of information will not be discussed with any persons outside the agency or in the presence of other clients or visitors without a properly executed release of information form signed by the client. Additionally, client information will not be discussed with any other employee or indirectly involved agency-related party unless this communication is deemed necessary to ensure the well being of or integrity of the client or the agency.

Exceptions to this policy would include:

- Disclosure of information in response to a court order.
- Member being in danger, including a health or other crisis or if the member is being exploited. The director my need to contact local outside resources for help.
- Suspected fraud or other Federal or State violations of the law.

In the case of a referral or consultation with other service provider, staff will inform the client of the intended communication and obtain the appropriate approval for release of information.

As a recipient of services provided by Colonie Senior Service Centers, Inc., I have been informed of policies regarding confidentiality.

Signature _____ **Date**_____
(Responsible Party)

Relationship if other than Participant _____

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 understand that this information is being collected to help in providing services under the State Office for the Aging and local Offices for the Aging. It also helps to identify other services that I may need. I understand that this information is needed 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 **Access Transit Services Inc.** of all requested records, including but not limited to, personal information, health information, and any other information concerning me that I have provided to **Access Transit Services Inc.** to the following entities, so they can make referrals for services that I may need, or for the purposes identified as follows:

Transporters
Doctor/Medical Offices/Pharmacy

NY Connects 518-447-7177
Albany County Department for Aging

Emergency Contacts listed on Registration form

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.

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.

_____ _____
Signature of individual or legal representative *Date*

_____
Individual's name (Print)

_____
If legal representative, provide name and relationship to individual

~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ **FOR OFFICE USE ONLY** ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~

ATTESTATION
To be completed by worker

I attest that informed consent, as indicated, was obtained from the above individual, who provided his/her signature above. All appropriate processes were followed, and consent was provided voluntarily.

_____ _____
Signature *Date*

_____
Print

COLONIE SENIOR Service Centers, Inc. | Transportation Services
6 Winners Circle, Albany, NY 12205
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Section A:

Request for Wheelchair Transportation Service

Must be completed and signed by applicant's physician

Date _____

Dear Dr. _____

Your patient, _____, (patient's full name) has requested Wheelchair Transportation Service through our agency. The Wheelchair Transportation Service provides a lift equipped medical transport van. To provide or continue providing Wheelchair Transportation Service, we must receive a notice in writing from you.

To be eligible to receive Wheelchair Transportation Service, the individual must have a physical impairment which prevents them from independently accessing our regular transportation service. By signing below, you certify that this individual is wheelchair bound and requires Wheelchair Transportation Service.

Signature of Doctor _____

Printed Name of Doctor _____

Address: _____

_____

Phone Number: _____

Date: _____