7101 WYOMING STREET, WESTMINSTER, CA 92683
TRANSPORTATION DEPARTMENT PHONE: (714) 702-1587 FAX: (714) 893-0592
MARCELA TICAS m.ticas@abrazarinc.com, LESLIE AGUILAR l.aguilar@abrazarinc.com,
IBET VILLALPANDO i.villalpando@abrazarinc.com, NANCY GRANADOS n.granados@abrazarinc.com
LETICIA CHAVOLLA-SALAZAR l.chavolla@abrazarinc.com, ELLIE DREILING e.dreiling@abrazarinc.com

ABRAZAR JARC PROGRAM APPLICATION

PLEASE SIGN AND DATE ALL FORMS PRIOR TO SUBMITTING. INCOMPLETE APPLICATIONS WILL BE RETURNED.

Last Name:_____ First Name:_____ Date:_____

Date of Birth:_____ **Age:** _____ Male:_____ Female:_____

Address:_____ Apartment/Unit #:_____

City:_____ Zip Code:_____

Primary Contact #: (___)_____ (2nd Phone #): (___)_____

1. Do you have any physical or functional limitations? ☐Yes ☐No
   If yes, please describe:_____

   _____

2. Do you require a mobility device or special equipment for transport?
   Please check all that apply: ☐Yes ☐No

   Cane_____ Walker_____ Wheelchair_____ Scooter_____ Oxygen_____ Other (service dog, etc….) Any other special circumstances:_____

   If yes, are you able to enter/exit the vehicle without your mobility device?

   _____ ☐Yes ☐No

   Are you able to transfer from a wheelchair to seat with/without assistance?

   _____ ☐Yes ☐No

3. Will a personal care attendant or assistant be traveling with you? ☐Yes ☐No

4. Do you require door-to-door assistance? ☐Yes ☐No
   If yes, please describe reasons why:_____

   _____

   _____

   _____

5. Please list your primary appointment (s) Name: _____

Address:_____Suite #:____City:_____Zip Code:_____

Phone: (___)_____ Note (Purpose): _____

6. How often do you anticipate needing to use the transportation service?
Daily_____Weekly____Monthly___Other (note)_____

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AM P/U REQUEST					
PM P/U REQUEST					

7. Emergency Contact Name:_____

Relationship:_____Phone #:_____

8. How do you get to your appointments now?_____

_____

9. Do you own a vehicle and are you able to drive?_____ ☐Yes ☐No

My signature verifies all information in this application to be true.

_____

Applicant signature **Date**

The following information is gathered for statistical data only and does not affect your eligibility:

How did you hear about the program?_____

Ethnic background: ☐Asian ☐Black ☐Hispanic ☐White ☐Native American ☐Other___

Annual Income per individual (MANDATORY): _____

☐Financial Hardship Waiver Requested

PROGRAM USE ONLY

- Referrals to alternative transportation provided:_____
- Exceptions (temporary, unrestrictive etc.): _____
- Need for follow-up contact:_____
- Annual Income: ☐At or below 150% FPG ☐Above 150%FPG ☐Financial Hardship Waiver

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ABRAZAR JARC PROGRAM WAIVER

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I hereby acknowledge that the transportation is a service provided by ABRAZAR and funded by the County of Orange, OCTA. I hereby waive the right to make any claims against ABRAZAR and the County of Orange, or their officials, employees and volunteers, for any injuries, damages, charges or expenses, including attorney's fees which might be sustained as a result of my participation in the JARC Program. I also acknowledge that ABRAZAR reserves the right to refuse transportation service.

PLEASE PRINT:

Name: _____ **Date:** _____

Address: _____

City: _____ **Zip Code:** _____

Phone: (____) _____

Client signature: _____

Caregiver signature (*if applicable*): _____

EMERGENCY CONTACT (1): _____ **RELATIONSHIP:** _____ **PHONE:** (____) _____

EMERGENCY CONTACT (2): _____ **RELATIONSHIP:** _____ **PHONE:** (____) _____

Please return this form to the Mobility Manager (s), Leslie, Marcela, Leticia, Ibet, Nancy or Ellie Dreiling. **You can mail, fax, or drop off your application in the enclosed envelope**. Services can be scheduled after all forms have been submitted and approved. Confirmation of approval will be mailed within five business days after receipt of completed forms.