



Baytown Resource & Assistance Center
COMMUNITY DEVELOPMENT TRANSPORTATION PROGRAM
GENERAL INFORMATION

The BRAC Community Development Transportation Program is sponsored by the City of Baytown Community Development Block Grant Program in collaboration with the Harris County Office of Transit Services Division. Together BRAC and Harris County can provide two transportation options under the Rides Program and Harris County Transit. The goal of the Program is to provide eligible residents with non-emergency transportation services within the city limits of Baytown and to/from Houston for medical appointments.

ELIGIBILITY REQUIREMENTS

1. Applicants must be a resident of the City of Baytown.
2. Applicants must be 65 years of age or older, have a certified disability, or receive a referral for domestic violence/sexual assault.
3. Applicants must complete the application for services and submit in person.
4. Applicant's household annual gross income must not exceed the below-stated maximum income limits.

No. in Household	Annual Maximum Gross Income*
1	\$15,750
2	\$18,000
3	\$20,780
4	\$25,100
5	\$29,420
6	\$33,740
7	\$38,060
8	\$42,380

HOW TO APPLY

Contact the Baytown Resource & Assistance Center Office at (281) 424-5752 for general information, program guidelines and an application form. Completed applications must be submitted in person at the BRAC Office located at 5309 Decker Drive, Baytown, Texas.



Community Development Transportation Program

BAYTOWN RESOURCE & ASSISTANCE CENTER

5309 Decker Drive - Baytown, TX 77520 - 281-424-5752

www.baytownresourceandassistancecenter.org

Applicant Information:

First Name: _____ Last Name: _____ M.I.: _____

Date of Birth: ___/___/___ Please circle which applies: Over 65 Disabled Domestic Violence

Ethnicity (circle): Hispanic Not-Hispanic
Race (circle): White American India/Alaskan Native Asian
Black/African American Native Hawaiian/Pacific Islander

Home Number: _____ Mobile Number: _____ Alternate Number _____

Sex (M/F): _____ Single _____ Married _____ Divorced _____ Widowed _____ Female Head of Household _____

Ambulatory _____ or Wheelchair Bound _____ How far is the nearest transit stop to your home _____

Applicant Address Apt # Zip Code Name of complex or subdivision

Please list a Relative, Friend, or Neighbor who can usually contact you:

Name Relation Home Phone Work Phone Mobile Phone

Have you ever applied for METROLift service?

Yes _____

No _____

Were you approved by METROLift?

Yes _____

No _____

If this program was **not** available, what would be your option(s) for transportation? Check all that apply.

- Your own car _____
- Family or neighbor (by car) _____
- General public transit _____
- Special transportation _____
- Taxi _____
- Walk _____

What percentage of travel is accomplished by:

- Your own car _____%
- Family or neighbor (by car) _____%
- General public transit _____%
- Special transportation _____%
- Taxi _____%
- Walk _____%

For what type(s) of trips will you use this transportation Program for? Check all that apply.

- Houston Dr. appointments _____
- Baytown Dr. appointments _____
- Pharmacy _____
- Grocery shopping _____
- Social Services _____
- Other _____

Do you require additional assistance. Check all that apply.

- Boarding and/or unboarding _____
- Carrying small packages _____
- Other (List below) _____

Applicant Comments or Specific Needs: _____

ALL APPLICANTS MUST APPLY IN PERSON

**BAYTOWN RESOURCE AND ASSISTANCE CENTER
COMMUNITY DEVELOPMENT TRANSPORTATION PROGRAM
DISABILITY CERTIFICATION**

TO BE COMPLETED BY APPLICANT:			
First Name	Middle Name	Last Name	
Street Address	City	State	Zip
Phone Number	Social Security Number	Date of Birth	
TO BE COMPLETED BY DOCTOR:			
First Name	Middle Name	Last Name	
Doctor's Street Address	City	State	Zip
Nature of Disability	Phone Number	Type of Practice/Degree	

In accordance with federal law and regulation published by the Department of Housing and Urban Development, it is necessary to verify the disability status of the Applicant identified hereinabove. The information provided will be used solely for the purpose of determining the applicant's eligibility for participation in the Community Development Transportation Program funded by a Community Development Block Grant.

I, the above-referenced doctor, hereby certify that in my professional opinion, the above-named applicant meets the following marked criteria:

- _____ The applicant has a disability as defined in 42 U.S.C.S. 423 --
- (A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months; or
 - (B) in the case of an individual who has attained the age of 55 and is blind (within the meaning of "blindness" as defined in section 216(i)(1) [42 U.S.C.S. §416(i)(1)]), inability by reason of such blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time.

The applicant has a developmental disability as defined in 42 U.S.C.S. §6001 -- a severe, chronic disability of an individual 5 years of age or older that_

- (A) is attributable to a mental or physical impairment or combination of mental and physical impairments;
- (B) is manifested before the individual attains age 22;
- (C) is likely to continue indefinitely;
- (D) results in substantial functional limitations in three or more of the following areas of major life activity_
 - (i) self-care;
 - (ii) receptive and expressive language;
 - (iii) learning;
 - (iv) mobility;
 - (v) self-direction;
 - (vi) capacity for independent living; and
 - (vii) economic self-sufficiency; and
- (E) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of lifelong or extended duration and is individually planned and coordinated, except that such term, when applied to infants and young children means individuals from birth to age 5, inclusive, who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services are not provided.

SIGNED this the ___ day of _____, 20__.

(Stamp of Doctor's Office)

Signature of Doctor

Community Development Transportation Program

Checklist of Items/Forms Needed

Applicant's Name: _____

Household Size: _____

Elderly: _____

Disabled: _____

		SUBMITTED	NEED
Must have:	Identification		
	Social Security Card		
Must have at least one:	Residency		
	Water		
	Electricity		
	Gas		
	Phone		
	Lease/Deed		
Must have at least one:	Age		
	State-Issued ID		
	State-Issued Driver's License		
Must have if under age 65:	Disability		
	Doctor's Certification Form		
Must have proof of all sources of income:	Income		
	Social Security Award Letter		
	Retirement/Pension Verification		
	Veteran's Award Letter		
	Food Stamp Award Letter		
	Self-Employment Verification		
	Welfare/AFDC Verification		
	Supplemental Social Security		
	Income Tax Returns		
	Child Support/Alimony		
	Employment Verification		
	Investment Interest		
	Bank Statements (last 3 months)		
	Housing Assistance		
Regular Gifts			
Other Source(s) of Income			