**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES**
**Transportation Remuneration Incentive Program (TRIP)**
**Application/Redetermination Form**

| Do Not Write in This Space –<br>For Department Use Only<br><br>Case No.:_____<br>o Application<br>o Redetermination |
|---|

1. Date of Application/Redetermination _____

2. Name: _____

3. Address (Street and Box #): _____
   City, State, Zip: _____

4. Directions to your home: _____
   _____
   _____

5. Telephone Number: _____ If you do not have a telephone, can you be contacted by calling a relative or neighbor? Yes _____ No _____ If yes, give their name and telephone number:
   Name: _____ Telephone: _____

6. Have you ever received TRIP tickets before? Yes _____ No _____

7. List the following information about yourself and all other persons living in your household:

| Full Name | Date of Birth | Social Security Number | Relationship | *Income Source | **Gross Income Amount |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

*Identify Source of Income such as Social Security, Black Lung, Workers' Compensation, Public Assistance, Salary, etc.
** If you receive a paycheck, enter your gross pay. This is the amount before any deductions. (Income taxes, etc.)

8. Eligibility for Extra Ticket Books – Check appropriate blocks:

   □ One round trip from my home to nearest city or town costs more than $8 per month.
   □ Visiting doctor, clinic, sheltered workshop or hospital costs more than $8 per month. (Doctor's statement is needed)
   □ Forced use of more expensive type of transportation to visit doctor, clinic, sheltered workshop, costs more than $8 per month. (Doctor's statement is needed)
   □ Need someone to travel **with me or for me** because of age, illness or disability. This includes medical appointments and to pharmacy, etc. (Doctor's statement is needed)

9. Complete the following information regarding the disability of you or any member of your household who is mentally or physically handicapped:

| | | | **Has this Disability been verified by a Medical Statement?** | |
|---|---|---|---|---|
| **Name** | **Type of Disability** | **Date of Disability** | ***Yes** | ****No** |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

* If disability has been determined by any State or Federal agency such as Social Security, Veteran's Administration, Department of Health and Human Resources, Worker's Compensation, Black Lung, etc., no additional information is necessary.

** If the disability has not been established, it will be necessary to furnish a doctor's statement stating when disability began and the approximate length of the disability. (In order to establish eligibility for disability, the period of anticipated disability must be for one year or longer.)

10. If you need to have someone else to purchase your transportation tickets, complete the following: (Do not complete if you are able to purchase your own tickets.)

_____ _____
First and Last Name Mailing Address

11. Before your application can be processed, you must read and answer the following statements:

Yes ____ No ____ I certify I have read or had read to me all the statements on this form and that the information is true and complete to the best of my knowledge.

Yes ____ No ____ I agree to let the local Department of Health and Human Resources know immediately if:
1. I move.
2. There is an increase or decrease in my income.
3. I am no longer disabled or handicapped.

Yes ____ No ____ I understand I may request a review on the decision made on my application for transportation tickets and I may request a fair hearing regarding any action to which I do not agree.

Yes ____ No ____ I understand that if I violate any of the applicable regulations, I may be denied the privilege of acquiring and using transportation tickets in the future.

Yes ____ No ____ I understand that my case may be selected for a review of eligibility and I will cooperate fully if my case is selected.

_____ _____
Your signature Signature of your husband or wife

_____ _____
Signature of Person who helped you fill out this form Date

THIS APPLICATION CANNOT BE PROCESSED UNLESS IT IS SIGNED BY YOU, YOUR SPOUSE (IF ANY), AND THE PERSON WHO ASSISTED YOU.