County of Fairfax, Virginia

To protect and enrich the quality of life for the people, neighborhoods and diverse communities of Fairfax County

The following questions and answers have been compiled to assist you in understanding the FASTRAN CRITCAL MEDICAL CARE PROGRAM (CMCP).

What is the Critical Medical Care Program?

This transportation service is for Fairfax County residents who must undergo life sustaining treatments. This includes dialysis, chemotherapy/radiation, physical therapy, brain injury therapy and water therapy. Transportation service under this program is not guaranteed, but is provided on a space available basis.

Are there any fees to use this program?

Yes. Fees listed below are based on household size and gross income:

Household Size	For Income Up To and Including:			For Income Over:	
	225%	300%	375%	450%	451%
1	$26,483	$35,310	$44,138	$52,965	$53,083
2	$35,843	$47,790	$59,738	$71,685	$71,844
3	$45,203	$60,270	$75,338	$90,405	$90,606
4	$54,563	$72,750	$90,938	$109,125	$109,368
5	$63,923	$85,230	$106,538	$127,845	$128,129
6	$73,283	$97,710	$122,138	$146,565	$146,891
One Way Fare	$0.00	$2.00	$3.00	$4.00	$5.00

What are accepted forms of income verification?

It is not necessary to for applicants to submit income verification if that applicant is receiving services from one of the following agencies listed below (these agencies can verify your income).

- You are a client of the Department of Family Services, the Health Department or Housing and Community Development OR
- You are living in federally subsidized housing and your rent is based on your income.

Applicants who are not able to have their income verified by one of the above agencies must submit documentation. Accepted forms of documentation are (copies are acceptable):

- A letter of award from the Social Security Administration OR
- An unemployment or Workman's Compensation statement OR
- An agreement showing the amount of child support or alimony OR
- A statement of monthly pension benefits OR
- An employer statement (on company letterhead) stating your salary or most recent pay stubs OR
- A bank statement showing automatic deposit of Social Security check, SSI check, and/or retirement benefits.

Department of Neighborhood and Community Services
Human Services Transportation
12011 Government Center Parkway, 10th Floor
Fairfax, VA 22035
703-222-9764, TTY 711 Fax: 703-653-9457
www.fairfaxcounty.gov/ncs

Parent's income is not considered when determining eligibility for an adult child (18 and over) still residing at home. Also eligibility for elderly residents residing with a child is determined solely on the applicant's income.

Example A: In a family of three (two adults and an 18 year old) the income of the two adults is not considered when determining eligibility of the 18 year old.

Example B: An elderly couple residing with their adult children will not have their children's income considered when determining eligibility.

HOW WILL I KNOW IF MY APPLICATION HAS BEEN RECEIVED?

You will be sent notification through the U.S. Mail which states:

- Your application has been approved and you are certified for use of FASTRAN CMCP or
- Your application is incomplete and what information is required to complete the application.

WHERE CAN FASTRAN TAKE ME?

FASTRAN can take you to locations in Fairfax County as well as locations in Arlington County and the City of Alexandria.

CAN FASTRAN TRANSPORT ME IF I USE A WHEELCHAIR?

FASTRAN vehicles are lift equipped for riders with wheelchairs. Steps into the interior of FASTRAN vehicles have been specifically designed to accommodate the disabled. Lifts and tie-downs accommodate most commonly used wheelchair models. Collapsible wheelchairs are provided on request for persons with "scooter" motorized wheelchairs that cannot be transported. In this case, you will be transferred to a collapsible wheelchair and your "scooter" wheelchair will be loaded and transported.

WHAT ARE FASTRAN'S CMCP HOURS?

CMCP transportation service may be available **Mon-Fri 6 a.m. – 6 p.m. based on space availability** for oncology, dialysis, and physical therapies. A doctor's note or prescription must be on file with *Fastran* for all physical therapies. Please also supply a schedule with treatment beginning and ending dates and times.

I REQUIRE A COMPANION WHEN I TRAVEL. MUST MY COMPANION ALSO REGISTER WITH FASTRAN IN ORDER TO RIDE ON THE VEHICLE?

No. A companion does not need to be registered.

AM I GUARANTEED A SEAT ON A FASTRAN BUS ONCE I AM REGISTERED FOR CMCP?

Service is provided on a space available basis.

ARE THERE ANY RESTRICTIONS IN WHERE I MAY RECEIVE DIALYSIS TREATMENT?

FASTRAN should transport to the dialysis center closest to the client's home. Clients should ask their nephrologist about dialysis facilities where they practice. It may impact whether FASTRAN will be available. If you have a disability which prevents you from using Metro/Connector service, you may also be eligible for Metro Access service. Call Metro Access at 301-562-5360 for more information.

FASTRAN CRITICAL MEDICAL CARE PROGRAM
Neighborhood and Community Services
Fastran
12011 Government Center Parkway, 10th Floor
Fairfax, Virginia 22035-1115
703-222-9764, TTY 711
Fax: 703-653-9457

ID #_____

Date_____
(OFFICE USE ONLY)

NOTE: AN APPLICATION MUST BE FILLED OUT FOR EACH APPLICANT

Name_____
LAST FIRST MI

Telephone # _____ _____
HOME PHONE WORK PHONE

Address_____Zip Code_____

Emergency Contact_____Daytime Phone _____

Relationship_____ Household Size_____

Sex (Circle one) Male Female D.O.B._____/_____/_____

Do you use a wheelchair?_____A motorized chair? _____A walker?_____

Is your rent based on your income? _____ _____
YES NO

Are you currently a client of:
Department of Family Services? _____ _____
YES NO

Health Department? _____ _____
YES NO

Housing and Community Development? _____ _____
YES NO

If YES to any of the above, County Representative's name_____

County Agency_____Telephone#_____

Are you a Medicaid recipient?_____If YES, Medicaid #_____

INCOME STATUS ***PLEASE SUBMIT PROOF***

PLEASE INDICATE THE SOURCE, AMOUNT, AND **SUBMIT PROOF** OF MONTHLY INCOME:

SOURCE OF INCOME	**MONTHLY AMOUNT**
AID TO DEPENDENT CHILDREN **(ADC)**	$_____
GENERAL RELIEF **(GR)**	_____
REFUGEE ASSISTANCE	_____
SUPPLEMENTAL SECURITY INCOME **(SSI)**	_____
SOCIAL SECURITY DISABILITY INSURANCE **(SSDI)**	_____
SOCIAL SECURITY AWARD **(SSA)**	_____
RETIREMENT / PENSION	_____
WORKMAN'S COMPENSATION	_____
UNEMPLOYMENT COMPENSATION	_____
CHILD SUPPORT	_____
ALIMONY	_____
MONTHY DIVIDENDS	_____
EMPLOYMENT	_____
OTHER INCOME IF NOT LISTED ABOVE	_____

**IF EMPLOYED, NAME AND PHONE # OF EMPLOYER_____

** **I DO AFFIRM TO THE BEST OF MY KNOWLEDGE THAT ALL THE ABOVE INFORMATION IS TRUE. IN ADDITION, I UNDERSTAND THAT MY SIGNATURE ON THIS APPLICATION GIVES PERMISSION TO THE FAIRFAX COUNTY DEPARTMENT OF NEIGHBORHOOD AND COMMUNITY SERVICES, HUMAN SERVICES TRANSPORTATION TO MAKE CONTACT WITH OTHER HUMAN SERVICE RELATED AGENCIES FOR DETERMINING ELIGIBILITY FOR THE FASTRAN CRITICAL MEDICAL CARE PROGRAM.**

_____ _____

APPLICANT SIGNATURE **DATE**