**FASTRAN CRITICAL MEDICAL CARE PROGRAM**
**Frequently Asked Questions**

**What is the Fastran Critical Medical Care Program?**
The Fastran Critical Medical Care Program (CMCP) is a transportation service available to Fairfax County residents who must undergo life sustaining treatments, including dialysis, radiology, chemotherapy, brain injury therapy, physical therapy and water therapy.

**Is a medical certification required?**
Yes. Normally, the medical certification is provided by a physician or dialysis or oncology center.

**Are there any program fees?**
Yes. The following program fees 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 | $25,133 | $33,510 | $41,888 | $50,265 | $50,377 |
| 2 | $34,043 | $45,390 | $56,738 | $68,085 | $68,236 |
| 3 | $42,953 | $57,270 | $71,588 | $85,905 | $86,096 |
| 4 | $51,863 | $69,150 | $86,438 | $103,725 | $103,956 |
| 5 | $60,773 | $81,030 | $101,288 | $121,545 | $121,815 |
| 6 | $69,683 | $92,910 | $116,138 | $139,365 | $139,675 |
| **One Way Fare** | **$ 0.00** | **$ 2.00** | **$ 3.00** | **$ 4.00** | **$ 5.00** |

**Is proof of income required?**
Yes. However, if an applicant is receiving services from any of the agencies listed below, CMCP program staff will contact the appropriate representative to verify your income.

- Department of Family Services
- Department of Neighborhood and Community Services
- Department of Housing and Community Development – you are living in federally subsidized housing and your rent is based on your income.

Applicants who are not receiving services from one of these agencies must submit proof of income.

**What are acceptable forms of proof of income?**
Copies of the following are accepted as proof of income:

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

Note: Parent's income is not considered when determining eligibility for an adult child (18 and over) who resides at the 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 in determining the 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?**

CMCP program staff will notify you through the U.S. Mail stating:

- your application has been approved, or
- your application is incomplete and the information required to complete the application.

**Am I guaranteed a seat on a Fastran bus once I am approved for CMCP?**

No. Service is provided on a space-available basis.

**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.

**What are the hours of service?**

Transportation is generally available on a **space available basis** from **5 a.m. to 9 p.m.** for dialysis and oncology patients and from **10 a.m. to 2 p.m**. for physical therapy patients. Physical therapy patients must request service by 3:00 p.m. the preceding business day.

**Are there any restrictions on where I may receive dialysis treatment?**

Yes. Fastran transports clients to the dialysis center closest to a client's home. Clients should ask their nephrologist about the 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 301-562-5361 for more information.

**I require a companion when I travel. Does my companion need to apply?**

No. A companion does not need to apply.

**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 upon request for persons with "scooter" motorized wheelchairs. In this case, riders will be transferred to a collapsible wheelchair and the "scooter" wheelchair will be loaded and transported.

**(OFFICE USE ONLY)**

ID #_____ Date_____

**FASTRAN CRITICAL MEDICAL CARE PROGRAM APPLICATION**
**Fairfax County Department of Transportation**
4050 Legato Road, Suite 400
Fairfax, Virginia 22033
703-222-9764, TTY 711
FAX: 703-653-9457

**Please complete the application and attach medical certification and proof of income, unless the applicant's income can be verified by another Fairfax County agency. Mail or fax the completed application, medical certification, and proof of income, if required, to the address or fax number listed above.**

Last Name: _____ First Name: _____ Middle Initial: ____

Home Phone: _____ Work Phone: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Emergency Contact: _____ Daytime Phone: _____

Relationship: _____ Household Size: _____

Sex: ☐ Male ☐ Female Date of Birth (Month/Day/Year): _____

Do you use:

| | | |
|---|---|---|
| A wheelchair? | ☐ Yes | ☐ No |
| Motorized chair? | ☐ Yes | ☐ No |
| Walker? | ☐ Yes | ☐ No |

Are you currently a client of the:

| | | |
|---|---|---|
| Department of Family Services? | ☐ Yes | ☐ No |
| Department of Neighborhood and Community Services? | ☐ Yes | ☐ No |
| Department of Housing and Community Development? | ☐ Yes | ☐ No |
| Is your rent based on your income? | ☐ Yes | ☐ No |

If you are a currently a client of any of these agencies:
County Representative's Name: _____ Phone: _____

Are you a Medicaid Recipient? ☐ Yes ☐ No If YES, Medicaid#: _____



FCDOT Serving Fairfax County Since 1977

County of Fairfax 1742 Virginia

**FASTRAN CRITICAL MEDICAL CARE PROGRAM APPLICATION**

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

| **Source of Income** | **Monthly Amount** |
|---|---|
| Temporary Assistance to Needy Families (TANF) | $ _____ |
| 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 | $ _____ |
| Monthly Dividends | $ _____ |
| Employment | $ _____ |
| Other Income (If Not Listed Above) | $ _____ |

****If you are currently employed:**

Employer Name: _____ Employer Phone: _____

**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 Transportation to contact other human service-related agencies to determine eligibility for the Fastran Critical Medical Care Program.**

_____ _____

**APPLICANT SIGNATURE** **DATE**