

2020-2021

MEO Youth Transportation Services: COVID-19 Pandemic Process

Due to COVID-19, and the current fluctuating DOE schedules, this is our plan for MEO's Youth Transportation program for the school year 2020-2021:

- Service is provided Monday-Friday, excluding weekends and holidays.
- Youth centers/clubs will need to supply MEO with a list of pre-approved youth.
- All youth will need to submit applications for the 2020-2021 school year.
- There will NOT be any stickers distributed, but youth will need to have their ID upon pickup.
- Reservations will need to be made at least one day prior to service and can be booked up to two weeks in advance. Subscriptions are not possible at this time. Reservation hours are from 8AM-4PM Monday through Friday, excluding holidays and weekends.
- Youth and their families are responsible for cancelling trips in advance to prevent a No Show.
- Pickups will be based on a 330PM arrival, and are allowed from School and their residence.
- Returns will be based on a 530PM return, and are booked to their residence.
- Youth will be required to use a face mask at all times while on the bus.

Please note: This process is subject to change due to the uncertainty of the COVID-19 pandemic. Youth centers/clubs will be notified in the event of any changes.



COMPLETE PAGES 1-7

Human Service Transportation Applications

Trans ID _____

<input type="checkbox"/> ARC of Maui <input type="checkbox"/> Kalima O'Maui <input type="checkbox"/> Rural Shopping Shuttle	<input type="checkbox"/> Day Care <input type="checkbox"/> Day Health <input type="checkbox"/> I-Shuttle	<input type="checkbox"/> Ala Hou* <input type="checkbox"/> Easter Seals <input type="checkbox"/> Kaunoa Leisure / Wellness	<input type="checkbox"/> Dialysis* <input type="checkbox"/> Youth Trans <input type="checkbox"/> Senior Club	<input type="checkbox"/> Employment to Work for Low Income/Disabled Individuals**
Name		Birthdate	Sex <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Female <input type="checkbox"/> Unknown	
Address		City	State	Zip Code
Mailing Address		Phone Day	Evening	TDD/TTY
Health Insurance <input type="checkbox"/> NO Insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> State Children's Health Ins. <input type="checkbox"/> State Adult Health Ins. <input type="checkbox"/> Military Health Care <input type="checkbox"/> Direct-Purchase <input type="checkbox"/> Employment Based <input type="checkbox"/> Unknown / Not Reported	Race <input type="checkbox"/> White <input type="checkbox"/> Multi-race (2 or more) <input type="checkbox"/> African American or Black <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian & Other Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Unknown / Not Reported <input type="checkbox"/> Other	Ethnicity <input type="checkbox"/> Hispanic, Latino or Spanish origin <input type="checkbox"/> NOT Hispanic, Latino or Spanish origin <input type="checkbox"/> Unknown / Not Reported	Age <input type="checkbox"/> 0-5 <input type="checkbox"/> 55-59 <input type="checkbox"/> 6-13 <input type="checkbox"/> 60-64 <input type="checkbox"/> 14-17 <input type="checkbox"/> 65-74 <input type="checkbox"/> 18-24 <input type="checkbox"/> 75+ <input type="checkbox"/> 25-44 <input type="checkbox"/> Unknown / Not Reported <input type="checkbox"/> 45-54 <input type="checkbox"/> Reported	
Disabling Condition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Disconnected Youth <input type="checkbox"/> Youth 14-24 not working or in school	Military Status <input type="checkbox"/> Veteran <input type="checkbox"/> Active Military <input type="checkbox"/> Unknown / Not Reported	Work Status <input type="checkbox"/> Employed, Full-time <input type="checkbox"/> Migrant Seasonal Farmworker <input type="checkbox"/> Employed, Part-time <input type="checkbox"/> Unemployed (6 mths or less) <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed (Long-term for more than 6 months) <input type="checkbox"/> Unknown/Not Reported <input type="checkbox"/> Unemployed, (not in labor force)	
Limited English <input type="checkbox"/> Yes <input type="checkbox"/> No				
Level of Income See page 3 for gross income declaration	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated		Housing <input type="checkbox"/> Own <input type="checkbox"/> Other permanent Housing <input type="checkbox"/> Rent <input type="checkbox"/> Other _____ <input type="checkbox"/> Homeless <input type="checkbox"/> Unknown / Not Reported	
Education Level <input type="checkbox"/> 0-8 <input type="checkbox"/> High School Grad / GED <input type="checkbox"/> 2 to 4 year College graduate <input type="checkbox"/> 9-12/non-graduate <input type="checkbox"/> 12+ some post secondary <input type="checkbox"/> Unknown / Not Reported				
Family/Household Size <input type="checkbox"/> One member <input type="checkbox"/> Five members <input type="checkbox"/> Two members <input type="checkbox"/> Six members or more <input type="checkbox"/> Three members <input type="checkbox"/> Unknown / Not Reported <input type="checkbox"/> Four members		Family/Household Type <input type="checkbox"/> Single Parent Female <input type="checkbox"/> Non-related With/Children <input type="checkbox"/> Single Parent Male <input type="checkbox"/> Multigenerational Household <input type="checkbox"/> Single Person <input type="checkbox"/> Other: _____ <input type="checkbox"/> Two Parent Household <input type="checkbox"/> Unknown / Not Reported <input type="checkbox"/> Two Adults NO Children		

Mobility (Check appropriate item(s)) PCA Required <input type="checkbox"/> Yes <input type="checkbox"/> No (limited to one)		Annual Household Income See page 3			
<input type="checkbox"/> No limitation <input type="checkbox"/> Scooter <input type="checkbox"/> Child Restraint Seat	<input type="checkbox"/> Ambulatory <input type="checkbox"/> Wheelchair <input type="checkbox"/> Gurney	<input type="checkbox"/> Power Chair <input type="checkbox"/> Walk Aid Type _____ <input type="checkbox"/> Other _____			
Source of Family Income <input type="checkbox"/> Employment ONLY <input type="checkbox"/> NO Income <input type="checkbox"/> Employment + Other ONLY <input type="checkbox"/> Non-Cash Benefits ONLY <input type="checkbox"/> Employment + Other + Non-cash Benefits <input type="checkbox"/> Unknown / not reported <input type="checkbox"/> Employment + Non-cash Benefits <input type="checkbox"/> Other Sources ONLY <input type="checkbox"/> Other + Non-cash Benefits		Other Income Source <input type="checkbox"/> TANF <input type="checkbox"/> Social Security Disability Insurance (SSDI) <input type="checkbox"/> SSI <input type="checkbox"/> Unemployment Insurance <input type="checkbox"/> VA Service disability Comp <input type="checkbox"/> Pension <input type="checkbox"/> VA Non-Service Disability Pension <input type="checkbox"/> Child Support <input type="checkbox"/> Private Disability Insurance <input type="checkbox"/> Alimony or other Spousal Support <input type="checkbox"/> Workers Compensation <input type="checkbox"/> Unemployment Insurance <input type="checkbox"/> Retirement Income from Social Security <input type="checkbox"/> EITC <input type="checkbox"/> Other, Unknown / Not Reported			
Non-Cash Benefits <input type="checkbox"/> SNAP <input type="checkbox"/> Housing Choice Voucher <input type="checkbox"/> HUD - VASH <input type="checkbox"/> Other <input type="checkbox"/> WIC <input type="checkbox"/> Public Housing <input type="checkbox"/> Childcare Voucher <input type="checkbox"/> Unknown / Not Reported <input type="checkbox"/> LIHEAP <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Affordable Care Act Subsidy					
Military Status					
Emergency Contact		Relationship	Address	Phone Day	Evening
Client Signature				Date	

Work History

**Must be completed if Employment to work for low Income/disabled selected						
Name and location of Employer _____						
<input type="checkbox"/> Sunday	<input type="checkbox"/> Monday	<input type="checkbox"/> Tuesday	<input type="checkbox"/> Wednesday	<input type="checkbox"/> Thursday	<input type="checkbox"/> Friday	<input type="checkbox"/> Saturday
From:	From:	From:	From:	From:	From:	From:
To:	To:	To:	To:	To:	To:	To:

(This part is to be completed by a licensed physician or agency involved in programs for the disabled) *Must be completed if ALA Hou service or Dialysis selected.		
Please specify nature of applicant's disability		
Agency/Name	Mailing Address	Telephone #
Signature _____		Date _____

For Office Use Only

Application Approved Disapproved Eligible Programs

Notification Date: _____

Eligibility Certification by: _____

Comment: _____

• P.O. Box 2122, Kahului, Maui, HI 96733 • Tel. No. 877-7651 • Fax No. 871-2171 • Rev. 04-25-19 •

INCOME VERIFICATION - Required for all programs

NOTE: TO BE ELIGIBLE FOR EMPLOYMENT TO WORK SERVICE, YOU MUST SUBMIT A COPY OF YOUR MOST CURRENT TAX RETURNS

125% OF THE 2020 FEDERAL POVERTY GUIDELINES FOR HAWAII		
Persons in Family/Household	Poverty Guidelines	
	Annual	Monthly
1	\$17,975	\$1,497.92
2	\$24,325	\$2,027.08
3	\$30,675	\$2,556.25
4	\$37,025	\$3,085.42
5	\$43,375	\$3,614.58
6	\$49,725	\$4,143.75
7	\$56,075	\$4,672.92
8	\$62,425	\$5,202.08

For families/households with more than eight people, add \$6,350 to the annual for each additional person.

**You must submit proof of income in order to qualify for the Employment to Work for Low income or Disabled Individuals. Acceptable proof is the most current tax returns for all household members, or pay stubs for the last three pay periods for all household members.



Maui Economic Opportunity, Inc.

P.O. Box 2122
Kahului, HI 96733
808-249-2990 Fax: 808-249-2991
www.meoinc.org

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling 808-249-2990, extension 342, or by requesting one at the MEO offices.

Date

Signature

(Print or Type Name)

*As the representative of the above individuals, I acknowledge receipt of the Notice on his or her behalf.

Signature

Relationship

Date

MAUI ECONOMIC OPPORTUNITY, INC.
PARTICIPANT’S WAIVER OF CLAIM AND INDEMNITY

For and in consideration of Maui Economic Opportunity, Inc. providing me transportation service, I, _____, on behalf of myself, my sibling(s), parent(s), child(ren), relatives, heirs, estate, executors, and /or administrators, hereby waive, release, discharge, hold harmless and indemnify Maui Economic Opportunity, Inc., its officers and employees (hereafter the “Transportation Agency”), from and against any and all claims, suits, damages, costs, fees, (including, but not limited to, reasonable attorney’s fees), losses, expenses, causes of action, judgments, and liabilities of every nature or kind (collectively “liabilities”), in equity or law, in any manner arising out of or in connection with the Transportation Agency providing me transportation service, unless such liabilities are caused by the gross negligence or willful misconduct of the Transportation Agency.

I agree to abide by all bus and safety rules of the Transportation Agency.

If any provision of this agreement, or the application of same is held invalid, all remaining provisions of this agreement and the application of such provisions to circumstances other than those which are held invalid shall not thereby be held invalid, and to this end the provisions of this agreement are expressly understood and agreed by the parties to be severable.

PRINT PASSENGER’S NAME ABOVE

LEGAL GUARDIAN SIGNATURE (SELF OR OTHER)

DATE

OPTIONAL SIGNATURES

I have read, understand, and agree with the provisions in this waiver form.

Parent/Guardian

Date

NOTICE OF PRIVACY PRACTICES

May 2017

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures of Health Information

We may use health information about you to determine program eligibility or to obtain payment for service (such as sending billing information to a health insurance plan), for administrative purposes, and to evaluate the quality of service that you receive (such as comparing client data to improve service methods).

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, abuse or neglect reporting, auditing purposes, research studies, workers' compensation purposes, and emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the lobby of each office, and on our Web site. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Individual Rights

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we may charge you a small fee for each page. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than service, payment, or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You have the right to request that your health information be communicated to you in a confidential manner such as sending mail to an address other than your home. If this notice was sent to you electronically, you may obtain a paper copy of the notice.

You may request in writing that we not use or disclose your information for eligibility, payment, or administrative purposes or to persons involved in your care except when specifically authorized by you, when required by law, or in emergency circumstances.

We will consider your request but are not legally required to accept it

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request. Under no circumstance will you be retaliated against for filing a complaint.

Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice. If you have any questions or complaints, please contact:

Gay Sibonga, Chief Operating Officer
PO Box 2122
Kahului, HI 96733
808-249-2990 extension 342
gay.sibonga@meoinc.org