



TRANSPORTATION RIDES PROGRAM ONLY FOR RESIDENTS OF PASADENA

CHECK LIST

Please make sure the following check list is complete and all documents are included before sending application:

APPLICATIONS COMPLETED ONLINE MUST BE PRINTED, SIGNED AND DATED.

- All pages of application are complete, signed and dated
Application consists of 3 separate applications for:
 - City of Pasadena Transportation **RIDES** Program
 - Community Development Block Grant (CDBG) Individual Eligibility Form
 - Harris County **RIDES** Transit Registration Form

- If between the ages of 18 to 64 years and claiming a disability according to the definitions listed on the Verification of Disability Form, please include the Verification of Disability Form along with proof of disability. Applicant may be required to appear in person, provide current SSI Award letter, or Verification of Disability Form signed and dated by a Medical Professional.

- Provide a copy of valid driver's license or identification card with picture and current address (If address is not current on identification, provide a Current Utility Bill, or Current Signed Lease, or any other government approved document verifying address in the City of Pasadena along with a copy of picture identification.)

Application may be **personally turned in by scheduling an appointment** or it may be mailed to:

Transportation **RIDES Program**

c/o Parks & Recreation
3111 San Augustine Ave.
Pasadena, TX 77503

713 920-7988

www.pasadenatx.gov/rides

Or email a **clear scanned copy** to:

RIDES@PASADENATX.GOV or EAguirre@pasadenatx.gov

Please note that applications sent by fax or in a picture format by email will not be accepted.

Funded by the City of Pasadena's Community Development Department –
Community Development Block Grant (CDBG)

8/2025



TRANSPORTATION RIDES PROGRAM

c/o Parks & Recreation
3111 San Augustine Ave.
Pasadena, TX 77053
713- 920-7988

Name: _____
First Last M.I.

Date of Birth: ____/____/____
Age: _____

S.S. #: - -

Address: _____
Street Apt. # City State Zip

Phone Number: () _____ Alternate Number: () _____

Race: _____ Ethnicity: Non-Hispanic Male Female
Hispanic

TDL #: _____ OR TX ID#: _____

Disabled: YES NO

Military Veteran: YES NO

Name and Phone Number of Relative, Friend or Neighbor who can usually contact you:

Name	Relation	Phone Number
_____	_____	_____
_____	_____	_____

• ALL APPLICANTS MUST RESIDE IN THE CITY OF PASADENA

- Must be 65 years of age or older
- If between the ages of 18-64, must have a completed, signed and dated Disability Statement Form and disability must be according to the definitions listed on the Verification of Disability Form
- If applicant is claiming a disability as listed on the Verification of Disability Form, applicant must provide proof of disability (ex: Current SSI Award Letter) and may be asked to appear in person
- Provide a clear copy of valid Driver’s License or Identification Card with photo and current address
- If applicant does not have current address on identification, applicant must provide photo identification along with proof of address (ex: Current Utility Bill, Current Signed Lease or any other government approved form of proof of residency with the City of Pasadena)
- Provide an emergency contact person – name and phone number
- Please make sure application is thoroughly filled out, signed and dated

WITHOUT THIS INFORMATION YOU WILL NOT BE ELIGIBLE FOR THE TRANSPORTATION RIDES PROGRAM



TRANSPORTATION **RIDES** PROGRAM

c/o Parks & Recreation
3111 San Augustine Ave.
Pasadena, TX 77053

713- 920-7988

RIDES@PASADENATX.GOV

The above named applicant has examined the eligibility requirements of City of Pasadena Transportation **RIDES** Program, subsidized by Community Development Block Grant (CDBG) grant funding, and has submitted this application for participation in such program after certifying that all of the information as submitted is true and correct. It is expressly understood and agreed that should it be determined at any time by City of Pasadena Transportation **RIDES** Program, its officers, agents and/or employees that this application contains incorrect or incomplete information, the above named individual shall be disqualified from participation in the program and shall be required to repay City of Pasadena Transportation **RIDES** Program all expenses incurred as a result of such individual's participation.

CERTIFICATION:

*This section is to be signed by the applicant or by person authorized to sign for client. A witness is needed for any signature made by a mark. **I certify this application has been completed to the best of my knowledge with complete and accurate information.** I understand any false statements or omissions of facts relevant to my eligibility for assistance will be considered fraud, and that I may be prosecuted under applicable U.S. Codes for this fraud. **Furthermore, I understand that assistance is contingent upon availability of funds.***

Signature of Applicant

Date

Witness (if signed by a mark indication)

TITLE VI NOTICE

Transportation **RIDES** Program operates its program and services without regards to race, color and national origin in accordance with Title VI of the Civil Rights Act. Any person who believes she or he has been aggrieved by any unlawful discriminatory practice under Title VI may file a complaint with the **RIDES** Coordinator for the Transportation **RIDES** Program.

For more information on City of Pasadena's Transportation **RIDES** Program civil rights and the procedures to file a complaint,

Tammy DeLosSantos **713-475-7048** or Elsa Aguirre **713- 920-7988**;
email: TDelossantos@pasadenatx.gov or EAguirre@pasadenatx.gov ; or
schedule an appointment to visit our office at:

Transportation **RIDES** Program
3111 San Augustine Ave.
Pasadena, Texas 77503



COP Office Use only:

Age: _____

COPS

COPD

Office Use Only:	
Grant Code:	_____
Agency Code:	_____
Registered Date:	_____

8410 Lantern Point Drive, Houston, Texas 77054
 Main: (713) 368-RIDE (713-368-7433)
 Fax: (713) 437-4860
<https://rides.harriscountytexas.gov/>

Program Funded by
 Federal Transit Administration (FTA)
 (Grant funds have expiration dates)

Registration Form

APPLICANT:

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

Sex : male /female Race/Ethnicity: _____ Date of birth: ____/____/____

Home number: (____) _____ Alternate number: (____) _____

Email address (please print): _____

What is your preferred method of contact? E-mail? ____ Home phone? ____ Alternate phone? ____ Mail? ____

Primary language spoken in the home (Check One): English ____ Spanish ____ Vietnamese ____ Other _____

(Check One): Single ____ Married ____ Divorced ____ Widowed ____

Address of applicant:

Number	Street	Apt. #	City	Zip Code
Mailing address: (if different from above)				

Number	Street	Apt. #	City	Zip Code
--------	--------	--------	------	----------

Name and phone number of relative, friend, or neighbor who can usually contact you:

_____	_____	_____ (____)	_____
Name	Relation	Home Phone	Work Phone

Check this status if senior and/or a person with disabilities:

Older Adult(s) (age 65 & above) _____
 Person with disabilities _____
 Older Adult(s) (age 65 & above) AND person with disabilities _____

Mobility Status (Check One):

Ambulatory (able to walk) _____
 Wheelchair User _____

Are you a military veteran?

Yes _____
 No _____

Check ALL that apply:

Applied for METROLift _____
 Approved for METROLift _____
 Denied by METROLift _____

CERTIFICATION:

The section is to be signed by the applicant or by person authorized to sign for client . A witness is needed for any signature made by a mark. I certify this application has been completed to the best of my knowledge with complete and accurate information. I understand any false statements or omissions to the best of my knowledge with complete and accurate information. I understand any false statements or omissions of facts relevant to my eligibility for assistance will be considered fraud, and that I may be prosecuted under applicable U.S. Codes for this fraud. Furthermore, I understand that assistance is contingent upon availability of funds.

***A fee of \$30.00 will be charged to you for any stopped payments or returned items.
Funds added to the Rides Fare Card are non-refundable & non-Transferable ***

The above named applicant has examined the eligibility requirements of RIDES, subsidized by H-GAC funding, and has submitted this application for participation in such program after certifying that all of the information so submitted is true and correct. It is expressly understood and agreed that should it be determined at any time by RIDES, its officers, agents and/or employees that this application contains incorrect or incomplete information, the above named individual shall be disqualified from participation in the program and shall be required to repay RIDES all expenses incurred as a result of such individual’s participation.

Applicant

Date

Witness (if signed by a mark indication)

The office of RIDES – Specialized Transportation for Harris County is wheelchair-accessible. Reserved parking spaces are available.

The following documents are required:

- 1.) State issued identification card OR State issued drivers license
- 2.) Proof of disability:

Acceptable documents (submit (1) of the following):

- a.) Doctor’s certification form
- b.) Supplemental Security Income (SSI)
- c.) Social Security Disability Insurance (SSDI)
- d.) Other verification

TITLE VI NOTICE

Harris County operates its programs and services without regard to race, color, and national origin in accordance with Title VI of the Civil Rights Act. Any person who believes she/he has been aggrieved by any unlawful discriminatory practice under Title VI may file a complaint with Harris County.

For more information on Harris County’s civil rights program and the procedures to file a complaint, contact 832-927-4700, TTY Dial 7-1-1 (1-800-735-2988); email transit@csd.hctx.net; or visit our administrative office at 8410 Lantern Point Drive, Houston, Texas 77054. For more information, visit www.harriscountytransit.com

CDBG PROGRAM NAME: Transportation Rides Program

APPLICANT NAME:

DATE:

--	--

APPLICANT'S ADDRESS:

CITY:

STATE:

ZIP:

--	--	--	--

PURPOSE OF FORM:

In accordance with federal laws and regulations published by the Department of Housing and Urban Development, it is necessary to verify the disability status of the CDBG Program Applicant identified hereinabove. All information provided will only be used for the purposes of establishing eligibility documentation for the above referenced CDBG Program. The City of Pasadena's Community Development Department and its Subrecipient Agencies and/or Recipient Departments, are prohibited from asking about the nature of an applicant's disability, and medical professionals should not disclose specific details or diagnoses.

A person with disabilities is a person who:

- A. Has a physical, mental, or emotional impairment that:
 1. Is expected to be of a long, continued, and indefinite duration, and
 2. Substantially impedes his/her ability to live independently, and
 3. Is of such nature that the ability could be improved by more suitable housing conditions, or
- B. Has a developmental disability, as defined, in Section 102(7) of Development Disabilities Assistances and Bill of Rights Act (42 U.S.C. 6001-6007).

INSTRUCTIONS:

There are three (3) methods of verification of disability status listed below. Please select ONE (1) of the verification methods and provide the necessary documentation associated with that verification method. A copy of this form and verification documentation should be placed in the CDBG Program Applicant's eligibility file.

___ OBVIOUS DISABILITY	
Select this box if the applicant named above, in the reasonable judgement of the CDBG Program Director, has an obvious disability. Examples of obvious disabilities are blindness or permanent necessity of wheelchair use. No further verification of disability required.	
Signature of CDBG Representative:	

___ RECEIPT OF FEDERAL DISABILITY BENEFITS	
Select this box if the applicant named above receives disability-related Social Security ("SSDI"), Supplemental Security Income ("SSI"), Veterans' Administration ("VA"), or other federal benefits. Reasonable documentation includes a benefit verification letter from the federal agency providing financial assistance to the applicant or canceled checks or direct deposit documentation or like records. No further verification is required.	
Type of Documentation Provided:	

CERTIFICATION OF A MEDICAL PROFESSIONAL (certification must be made by someone other than applicant)

Select this box if the applicant named above DOES NOT have an obvious disability and/or DOES NOT receive disability-related federal benefits. If this box is selected the applicant's disability status can only be verified through certification by a medical professional by completing the following sections.

To the applicant claiming disability:

The undersigned medical professional has knowledge of whether the claimed disability meets the definition applicable to this verification so that you may qualify for assistance under the referenced CDBG Program. YOU ARE NOT OBLIGATED TO CONSENT TO THE RELEASE OF THIS INFORMATION. However, the CDBG Program Representative must receive the information requested from the medical professional to determine your eligibility for the CDBG Program. The CDBG Program Representative may request from the medical professional only the minimum information necessary to determine whether the applicable definition of disability has been met.

I hereby authorize the release of the requested information to the CDBG Program Representative.

Name of Authorized Person:	Signature of Authorized Person:	Date:
----------------------------	---------------------------------	-------

To the medical professional:

The City of Pasadena's Community Development Department and its Subrecipient Agencies and/or Recipient Departments have an obligation with the United States Department of Housing and Urban Development Community Development Block Grant Program to verify disability when providing assistance utilizing federal funds. The applicant has asserted that he/she has a disability which must be documented by a medical professional. An authorized individual has lawfully consented to release to the CDBG Program Representative the medical opinion below regarding the claimed disability status. All information provided by a medical professional will be used solely to establish disability status. Neither the City of Pasadena's Community Development Department nor its representatives may ask about the nature of an individual's disability, and medical professionals should not disclose specific details or diagnoses.

I hereby certify that the above-named applicant (check one) ___ DOES / ___ DOES NOT meet the definition of person with disabilities set forth in this verification

Signature of Medical Professional:	Title and Organization:	Date:
------------------------------------	-------------------------	-------

SIGNATURES:

Under penalties of perjury, I certify that the information presented in this document is true and accurate to the best of my knowledge and belief. I further understand that providing false representations herein constitutes an act of fraud. False, misleading or incomplete information may result in my ineligibility to participate in CDBG Programs that will accept this document. **WARNING: ANY PERSON WHO KNOWINGLY MAKES A FALSE CLAIM OR STATEMENT TO HUD MAY BE SUBJECT TO CIVIL OR CRIMINAL PENALTIES UNDER 18 U.S.C. 287, 101 AND 31 U.S.C. 3729.**

CDBG Program Representative Name: Elsa Aguirre	Date:
CDBG Program Representative Signature:	
Applicant's Name:	Date:
Applicant's Signature:	



INDIVIDUAL ELIGIBILITY FORM

For Community Development Block Grant Programs

In accordance with 24 CFR 570.506, agencies must acquire information to determine client eligibility as well as for general reporting purposes. To participate in this program that is funded by Federal Funds, you must fill out this form completely and accurately.

CLIENT ELIGIBILITY INFORMATION

CDBG Program Name: **Transportation Rides Program**

GENERAL

Name					
Address					
City		State		Zip	
Home Phone		Age		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Is this client a minor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Name of Guardian			

CLIENT INFO

Is client a Citizen or Permanent U.S. resident?	<input type="checkbox"/> Yes <input type="checkbox"/> No	TX Drivers / ID No.			
Is the client a resident of the City of Pasadena?	<input type="checkbox"/> YES		<input type="checkbox"/> NO		
Disabled	<input type="checkbox"/> Yes <input type="checkbox"/> No	Elderly	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Residency Proof Documentation Provided <i>(Example: driver's license / ID Card / Bill)</i>					
Primary language (optional):					
Ethnicity	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Non-Hispanic	Is Client a Veteran	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Race	<input type="checkbox"/> Black / African American	<input type="checkbox"/> White	<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/ Alaskan Native	<input type="checkbox"/> Other /Multi Racial
	<input type="checkbox"/> American Indian/Alaskan Native & White	<input type="checkbox"/> American Indian/Alaskan Native & Black	<input type="checkbox"/> Native Hawaiian/ Other Pacific Islander	<input type="checkbox"/> Asian & White	<input type="checkbox"/> Black/African American & White

INCOME

Total # of Household Members	<u>N/A</u>	Gross Annual Household Income	\$ <u>N/A</u>		
Adults (Age 18 & older)	<u>N/A</u>	Children (Age 17 & under)	<u>N/A</u>	Elderly (Age 62 & older)	<u>N/A</u>
Proof of Income Documentation Provided <i>(Example: SS Award Letter / W-2 form / Check Stubs)</i>	N/A				
Head of Household	<input type="checkbox"/> Male		<input type="checkbox"/> Female		

SIGN HERE

I certify that, to the best of my knowledge and belief, all the information on and attached is true, correct, complete, and provided in good faith. I understand that false or fraudulent information on, or attached to this request may be grounds for being ineligible to receive the assistance requested and may be punishable by a fine and/or imprisonment. I understand that any information I give may be investigated.					
Print Name					
Signature				Date	

STAFF ONLY

For Subrecipient Staff Only

Is Client Approved/Eligible for Services?	<input type="checkbox"/> YES <input type="checkbox"/> NO		National Objective Met: <input type="checkbox"/> YES <input type="checkbox"/> NO		
National Objective 570.208 Benefit to Low & Moderate Income Persons	<input type="checkbox"/> LMI Area Benefit	<input type="checkbox"/> LMI Limited Clientele	<input type="checkbox"/> LMI Housing Benefit	<input type="checkbox"/> LMI Jobs Creation	
	Client Income Level		<input type="checkbox"/> 0 – 30 %	<input type="checkbox"/> 31 – 50 %	<input type="checkbox"/> 51 – 80 %
LMILC - Presumed Benefit	<input type="checkbox"/> Abused children	<input type="checkbox"/> Battered Spouses	<input type="checkbox"/> Elderly	<input type="checkbox"/> Disabled	<input type="checkbox"/> Homeless <input type="checkbox"/> Illiterate
Name of Reviewer: Elsa Aguirre	Signature:			Date:	