CitrusConnection

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1290 Golfview Ave.. Bartow. 2nd Floor | 855-POLKBUS (765-5287) | WWW.RIDECITRUS.COM

Dear Customer:

Thank you for contacting Citrus Connection regarding transportation services.

CTD Program (Community Transportation Disadvantage Program) provides Transportation to the nearest facility for:

- medical/medical related services
- grocery store
- pharmacy
- Training
- Nutrition
- Education
- Employment and Recreation

With a three to fourteen day notice in advance (**does not include Saturday, Sunday or holidays**).

See below CTD Application process:

- Application reviewed
- Address evaluation, if needed
- Financial assessment to determine co-pay (**please send copies of documentation**)

If you have any questions, please contact the Regional Mobility Call Center (RMCC) for intake at (863) 534-5500, press option 3.

Transportation Coordinator – Intake Specialist
Lakeland Area Mass Transit District
d/b/a Citrus Connection
Regional Mobility Call Center (RMCC)

Rev 04/22/2019 TD COVER LTR/APP 2018 RMCC/Intake DK

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CTD Non-Emergency Transportation (Net) Program
Eligibility Checklist

The information on this checklist is required in order to determine your eligibility for reduced cost transportation services.

Please return the documentation listed below to your Intake Specialist by mail or fax:

Citrus Connection
P.O. Box 2026
Bartow Fl. 33831
Fax # 863-327-1366

If you have any questions regarding this checklist please call our office (863)534-5500 Option 3 for Intake; Monday through Friday, 8:00 a.m. to 5:00 p.m.

1. **Please send copy of Valid Drivers License or State Identification with current Polk County address**

2. Rent/Mortgage expense (please submit ONE **current** copy of the following items):
   - Rent receipt
   - Statement from landlord
   - Statement from individual with whom you live
   - Mortgage documentation
   - Referral letter from Talbot House/Homeless Coalition

3. Household Income (please submit ALL **current copies** of the following items that apply to your household income):
   - Social Security award letter
   - Pay stubs or wage statement from employer for 4 weeks
   - Unemployment Compensation documentation
   - Self-employment quarterly tax statement
   - Medicaid Card/Medicare Card
   - Medically Needy Share of Cost documentation
   - Any other income not listed

4. Expenses (please submit ALL **current copies** of the following items that apply to your household):
   - Housing expenses (Rent, Mortgage, Utilities, etc.)
   - Car payment documentation
   - Any other important documentation not listed such as insurance premium payments, etc.
   - **Estimated monthly grocery expense (please notate estimate on one of your expense copies)**

We are unable to accept documentation for Consumer Debts as a household expense.

PLEASE SEND COPIES OF CURRENT/MOST RECENT DOCUMENTS

Community Transportation Disadvantage Program Application
Return COMPLETED Form To
Citrus Connection
P.O. Box 2026
Bartow Fl. 33831
Phone # 863-534-5500 Opt# 3 / Fax # 863-327-1366

Section 1- Personal Information:

Last Name _____ First Name _____ MI _____

Address: _____

City _____ State _____ Zip_____

Mailing address (if different from above): Address: _____

City _____ State_____ Zip_____

Social Security #_____-_____-_____DOB:_____/_____/_____ Sex: _____ Number of household members? _____

Home Telephone # (_____)_____-_____Cell Phone # (_____)_____-_____

Emergency Contact _____Relationship_____

Phone Cell # (_____)_____-_____ or Home # (_____)_____-_____

Insurance Coverage: _____Polk Health Plan_____Other _____

What company provides you insurance?_____

Are you a Veteran of the US Armed Forces entitled to Veteran benefits?_____

What is the name, address and phone number for your Primary Care: _____

_____

When was your last visit? _____

Do you see any specialists?_____ What are their names, address and phone number?

1._____

2._____

3._____

How often do you see the specialist? _____

Where do you need transportation to? Grocery Store_____Pharmacy_____ Doctor_____

Client Mobility: Ambulatory: _____ Wheelchair:_____ Is there a Wheel chair ramp at your home?:_____

Do you require a PCA/Personal Care Attendant? _____ If yes, explain why?_____

_____

Do you use a service animal ?_____

Section 2- Transportation Availability

1. Do you or anyone in your household own a car?_____ Can this car be used for your transportation needs?_____

If not explain why?_____

2. What transportation do you currently use?_____

Section 3 – Public Transportation

1. Do you live within ¾ mile of a fixed bus route?_____

2. Can you use the fixed bus route for your transportation needs?_____

If no explain why?_____

What limitation do you have that would prevent you from using the fixed bus routes?_____

_____

3. Is there any other information you would like considered for your eligibility of Transit Services?_____

_____

I understand and affirm that the information provided in this application for CTD (NET) services is true and correct, to the best of my knowledge, and will be kept confidential and shared only with medical and transportation professionals involved in evaluating and determining my needs and eligibility for transportation. I understand that providing false or misleading information, or making fraudulent claims, or making false statements on behalf of others constitutes a felony under the laws of the State of Florida. I understand that incomplete forms will be returned and eligibility will not be determined until all information is provided.

Applicants Signature:_____ Date:_____

Person Completing Application:

Last Name: _____ First Name: _____

Street Address: _____ Apt/Bldg Number: _____

City: _____ State: _____ Zip: _____

Daytime Phone: _____ Ext: _____

Relationship to Applicant: _____

To be completed by Transit Personnel

Eligibility Criteria: _____

Application Processed Date: _____

Address Verification Date: _____

Results Letter Sent: _____

Financial and Eligibility Documents Received Dates: _____

Staff Signature: _____

Denial Date: _____

Denial Reason: _____

Lakeland Area Mass Transit District (DBA) Citrus Connection

HIPAA Medical Release Form

In order for Citrus Connection Management and PT Connect staff to process your application Paratransit Service Certification, we must ask that you complete and sign this information release form.

This release form authorizes the release of medical Information that is needed to determine the need for bus service. Failure to complete this form may result in denial of client/patient eligibility to ride the PT CONNECT. (HIPPA, Health Insurance Portability and Accountability Act of 1996)

Client/ Patient name _____

Date of Birth _____ Social Security # _____

City _____ State _____ Zip _____

Request information to be released from _____

Provide name of doctor, hospital, clinic of living facility _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Fax # _____

Client/Patient/Guardian/Responsible party signature _____

Relationship to client/patient _____ Date _____