ADA Application for PT Connect Paratransit Services

I. Instructions to Applicant or Representative:

Please read the enclosed Paratransit eligibility criteria carefully. If you believe that you meet **all** the criteria, please fill out the Applicant sections of the form.
Be sure to print and complete **all** information requested and sign where indicated.
Have the Health Care Professional sections completed and signed by an approved health care professional. ***All provided information will be verified and confirmed.***
You may attach supporting documentation. Your Health Care Professional may require that you sign an authorization for him/her to release your private medical information.

If you have any questions, please contact Polk Transit Regional Mobility Call Center 855-POLKBUS (765-5287) Monday through Friday between 8:00 a.m. and 5:00 p.m.

II. Instructions to Health Care Professional:

The Applicant is requesting certification to use ADA Paratransit service. ADA Paratransit is a door-to-door, shared ride program for individuals with physical or cognitive disabilities who are unable to use or access the fixed-route public transportation system, such as Winter Haven Area Transit or Citrus Connection and is in compliance with the Americans with Disabilities Act (ADA) of 1990.
Please complete the medical verification sections of this application. The information you provide must be based solely upon the individual=s physical or cognitive ability to use or access public transportation independently. Considerations based on the individual's age and/or the economic status of the applicant will not be used as certification for this service. Federal law is quite specific in defining who is eligible for this specialized service. The diagnosis of a potentially limiting illness or condition is not sufficient to document the need for ADA Paratransit service.

III. Determination of paratransit eligibility is not based solely on the information in this application. In addition, the Applicant may be required to participate in our Functional Assessment and Travel Training programs.

IV. Incomplete or illegible applications will be returned for completion, which may delay the Applicant's eligibility determination. The determination of eligibility will be made within 21 days from receipt of the completed application.

Information provided by the Applicant may be shared with our Functional Assessment Team. Please read the Notice of Privacy Practices contained in this application packet.

WHEN COMPLETE PLEASE RETURN TO:
Citrus Connection P.O. Box 2026 Bartow, FL 33831 Attention: PT Connect or Fax to: (863) 327-1366

SECTION A APPLICANT

OFFICE USE ONLY : Staff Signature: _____

New Application? Yes___ / No____ Recertification? Yes____ / No __Expire:_____

Eligibility From: _____ **-To**_____ **PCA (Y/N) ___ Archive Yr:**_____

Comments: _____

Part 1

PT Connect provides paratransit services in specially equipped vans to persons who cannot use the regular bus system. To be eligible for this service, individuals must have disabilities that prevent the use or access of regular bus system. Age of the rider is not by itself an eligible disability. Eligible persons must be unable to use or access the regular fixed route system. Please complete Section A of this form. Section B must be completed by a health care professional. ***Any false or misleading statements will be cause for revoking Access Van eligibility.***

Last Name: _____ **First Name:** _____ **M.I.** _____

Street Address: _____ **Apt./Bldg. Number** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: (___)_____ **Work Phone:** (___)_____ **Ext:**_____

Mailing Address (if different from address above):

Street Address:_____

City: _____ **State:** _____ **Zip**: _____

Emergency Contact: _____ **Relationship to Applicant:** _____

Home Phone: (___)_____ **Work Phone:** (___)_____ **Ext:**_____

Emergency Contact Address: _____ **Apt./Bldg. Number** _____

City: _____ **State:** _____ **Zip**: _____

SECTION A APPLICANT

Part 2
Client Mobility (Please check all that apply)

Need Assistance Walking	☐	Hearing Impaired	☐	Scooter	☐
Attendant Needed	☐	Mentally Impaired	☐	Guide Dog/White Cane	☐
No Bus Available	☐	Need Escort	☐	Sight Impaired	☐
Blind	☐	No Special Needs	☐	Stretcher	☐
Cancer Treatment	☐	No Taxi	☐	Walker	☐
Use Cane	☐	Nursing Home Patient	☐	Wheelchair, Can Transfer	☐
Car Seat	☐	Portable Oxygen	☐	Wheelchair, Cannot Transfer	☐
Too Far to Bus Stop	☐	Renal Patient	☐	Wide Wheelchair	☐

Part 3 Person Completing Application

Last Name: _____ First Name: _____ M.I. __

Street Address: _____ Apt./Bldg. Number

City: _____ State: _____ Zip:

Daytime Phone: (___) _____ Ext:

Relationship to Applicant:

Part 4 Notice of Privacy Practices

I understand that the purpose of this application form is to determine my eligibility for paratransit service. I understand that information about my disability will be kept confidential and Citrus Connection will only share my health information in a manner that is required to document my abilities or disabilities, and only with health professionals contributing to the evaluation or certification process as necessary to determine my eligibility for door-to-door transportation services. I authorize my medical representatives to release and share any and all medical information in this manner to Citrus Connection. I understand that providing false or misleading information could result in mu eligibility status being revoked. I agree to notify Citrus Connection within 10 days if there is any change in circumstances of if I no longer need to use the paratransit services.

Applicant's Signature: _____

Applicant's Printed Name: _____

☐Myself

☐Another person as his/ her personal representative (parent, guardian, family member etc.)

_____ _____

Signature of Patient or Personal Representative Date

SECTION B HEALTH CARE PROFESSIONAL

Part 1 Professional Verification

As a Health Care Professional familiar with the Applicant=s medical history, please complete this form documenting all conditions which prevent the use or access of fixed route bus service. Please assist us in certifying only those individuals, who because of disability, are truly unable to used regular bus service. (Please check all that apply.)

Applicant's Name: _____

☐Applicant cannot travel to or from a bus stop. ☐Applicant needs assistance to ride bus.

☐Applicant unable to ride an accessible bus.

Part 2

I have read the entirety of Section A prepared by the Applicant. ☐ Yes ☐ No

I agree with all the information in Section A. ☐ Yes ☐ No

Is the Applicant disabled? ☐ Yes ☐ No

Does this disability prevent use or access of regular bus service? ☐ Yes ☐ No

Can the Applicant wait outside in good weather? ☐ Yes ☐ No

Part 3

Capacity in which you are familiar with the Applicant**:** _____

Medical Diagnosis:_____ In your own words, please describe in detail what prevents the patient from independently traveling using regular or accessible buses:

_____

_____

Mobility Limitations:

Applicant can travel 200 feet without assistance? ☐ Yes ☐ No

Applicant can travel 1/4 mile without assistance? ☐ Yes ☐ No

Applicant can travel 3/4 mile without assistance? ☐ Yes ☐ No

Applicant can climb 12-inch step without assistance? ☐ Yes ☐ No

Applicant can wait outside without support for 10 minutes? ☐ Yes ☐ No

Applicant can safely navigate obstacles in travel to bus stop? ☐ Yes ☐ No

SECTION B HEALTH CARE PROFESSIONAL

Cognitive Limitations:

Applicant can give address and phone number? ☐ Yes ☐ No

Applicant can recognize a destination or landmark? ☐ Yes ☐ No

Applicant can deal with unexpected situations.? ☐ Yes ☐ No

Applicant can ask for, understand, and follow directions? ☐ Yes ☐ No

Applicant can safely travel through crowded/complex facilities? ☐ Yes ☐ No

Are there any other effects of this disability that we should be aware of? ☐ Yes ☐ No

If yes to the question above please explain.

Does patient need someone to travel with them? ☐Never ☐Sometimes ☐Always

For Always or Sometimes: Why?

Part 4 Please print name and title of Health Care Professional:

Please indicate type of profession:

Licensed Physician	☐	Licensed Psychologist	☐
Licensed Occupational Therapist	☐	Licensed Registered Nurse	☐
Licensed Mental Health Counselor	☐	Licensed Ophthalmologist	☐
Licensed Clinical Social Worker	☐	Licensed Audiologist	☐
Licensed independent Living Specialist	☐	Other (Licensed)	☐

License Number (NOT OPTIONAL): _____

State Issued: _____

Agency/Clinic(if any) of Health Care Professional:

Street Address: _____ **Apt./Bldg. Number** _____

City: _____ **State:** _____ **Zip:** _____

Phone: (___) _____ **Ext**:_____

Print Name: _____

Signature of Health Care Professional: (Required)_____ Date:_____