

## **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:**

**Polk Transit 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: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_

Emergency Contact Address: \_\_\_\_\_ Apt./Bldg. Number \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**SECTION A APPLICANT**

**Please check which condition(s) prevent you from accessing a regular bus:**

Distance to the bus stop. How far is the nearest bus stop?

Disability prevents the use of the fixed route bus system.

What is the disability that prevents you from using or accessing the wheelchair accessible fixed route bus?

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How does this disability prevent the use or access of our fixed route bus?

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Are there any effects of your disability of which we need to be aware? Please give specific answers that will assist us in making our determination. \_\_\_\_\_

**Part 3  
Mobility Limitations**

**Can you:**

- |  |  |  |  |
|--|--|--|--|
| Board a lift-equipped bus?               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Understand directions?                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Board a bus without a lift?              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Travel 200 ft. w/o assistance?                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Travel to the nearest bus stop?          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Travel 3/4 mile w/o assistance?                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Identify the correct bus?                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Balance while seated?                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Handle coins and/or tickets?             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Grip handles and railings?                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Climb a 12-inch step without assistance? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Can wait outside without support for 10 minutes? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you answered no to any of the above, why not?

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**SECTION A APPLICANT**

**Part 4**

**Access Limitations**

Can use lift-equipped bus, but cannot ride because:

- Lift cannot be operated where I board.
- Wheelchair/scooter cannot be placed on vehicle.

Unable to use lift-equipped buses because \_\_\_\_\_

Can get to and from a regular bus stop only if:

- There are curb cuts
- It is daytime
- There is a sidewalk
- No high levels of pollution
- Ground level or slightly inclined
- Receive travel training
- No extreme weather
- Other \_\_\_\_\_

What conditions or elements prevent you from getting to and from a bus stop? \_\_\_\_\_

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**SECTION A APPLICANT**

**Part 5**

**Client Mobility (Please check all that apply)**

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

**Part 6 Person Completing Application**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_  
 Street Address: \_\_\_\_\_ Apt./Bldg. Number \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Daytime Phone: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_  
 Relationship to Applicant: \_\_\_\_\_

**Part 7 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 my 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: \_\_\_\_\_

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 Handy Bus application (application for ADA 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 Handy bus service. **Failure to complete this form may result in the 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 \_\_\_\_\_