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: ____________

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 ____________________