

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 or email: ALLRMCC_EMPLOYEES@RIDECITRUS.COM

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:** _____

Preferred contact method: ___ telephone ___ text message ___ email

Email address: _____

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

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

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

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 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 use 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. (HIPAA, 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 _____