ADA Application for 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 section A of the form***. Be sure to print and complete **all** the information requested and sign where indicated. ***A Health Care Professional must complete Section B***. ***All the information provided 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 the Regional Mobility Call Center at local (863) 534- 5500 Option 3, or 855-POLKBUS (765-5287) Option 3, 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 Citrus Connection which 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 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. 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. Citrus Connection will grant temporary service eligibility beginning the 22nd day if the eligibility determination is not made within 21 days of receiving a 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.

ADA Application for Paratransit Services	For Office use only
Return Completed Form to: Citrus Connection 1120 George Jenkins Blvd., Lakeland, FL 33815 Attention: PT Connect Or Fax Number: (863)327-1366, or Email: **ALLRMCC_Employees@ridecitrus.com**	Client ID # _____ New applicant? Yes ____ No ____ Recertification? Yes ____ No ____ Expire: _____ Eligibility From: _____ To: _____ PCA (Y/N) _____ Archive Yr: _____ Comments: _____ _____ Staff Signature: _____

SECTION A - APPLICANT

PART 1 – Applicant's Information

PT Connect provides paratransit services in accessible vehicle to people who has limited ability to use the Fixed route bus system. To be eligible for this service, individuals must have disabilities that prevent the use or access of regular bus system. The age of the rider is not by itself an eligible disability.

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

D.O.B: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Provide Mailing Address if different from above:

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

E-mail: _____

Preferred contact method: Phone ☐ Text Message ☐ E-mail ☐

Emergency contact Name /Phone Number / relationship: _____

_____

PART 2 - Please check all that apply:

Use cane / walker	☐	Cancer treatment	☐
Use scooter / wheelchair	☐	Renal patient	☐
Use oversized wheelchair	☐	Hearing impaired	☐
Portable Oxygen	☐	Cognitive impaired	☐
Service animal	☐	Sight impaired	☐

SECTION A - APPLICANT

PART 3 – Notice of HIPAA / Medical Release Information

I understand that the purpose of this application 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 with Citrus Connection. I understand that providing false or misleading information could result in my eligibility status being revoked. Failure to complete this application may result in incomplete client eligibility to ride the PT Connect *(HIPPA, Health Insurance Portability and Accountability, Act of 1996)*.

Request information to be released from: _____

Provide name of doctor, hospital, clinic or living facility:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Applicant's Signature: _____ **Date:** _____

PART 4 – Person completing Application (if different from Applicant)

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

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

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

Relationship: _____ **Signature** _____ **Date:** _____

SECTION B – HEALTH CARE PROFESSIONAL

PART 1 – Professional Verification

As a Health Care Professional familiar with the Applicant 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 the regular bus service. (Please check all that apply.)

Applicant's Name: _____

PART 2

Medical Diagnosis: _____

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

_____

I have read the entirety 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 the disability prevent the use or access of regular bus service?	Yes ☐	No ☐

PART 3 - Mobility Limitations

Can the applicant travel ¾ mile without assistance?	Yes ☐	No ☐
Can the applicant wait outside without support for 10 minutes?	Yes ☐	No ☐
Can the applicant safely navigate obstacles in travel to the bus stop?	Yes ☐	No ☐

PART 4 – 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 safety travel through crowded/complex facilities?	Yes ☐	No ☐
Are there any other effects of this disability that we should be aware of?	Yes ☐	No ☐

SECTION B – HEALTH CARE PROFESSIONAL

Capacity in which you are familiar with the Applicant: _____

Does the patient need someone to travel with them?

Never ☐ Sometimes ☐ Always ☐

For Always or Sometimes, please explain why? _____

_____

PART 5 – Health Care Professional Information

All fields in this section must be completed in full by the health care professional. Incomplete or missing information may result in delays or affects the applicant's eligibility for services.

Please indicate your Licensed Profession:

Physician ☐	Occupational Therapist ☐	Registered Nurse ☐
Psychologist ☐	Mental Health Counselor ☐	Clinical Social Worker ☐
Ophthalmologist ☐	Independent Living Specialist ☐	Audiologist ☐
Other Medical Professional ☐	Which Profession: _____	

Print Name of Health Care Professional: _____

Agency/Clinic Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Ext.: _____

Signature of Health Care Professional: _____ **Date:** _____

State of Florida License Number: _____