



PASCO COUNTY, FLORIDA

"Bringing Opportunities Home"

Pasco County Public Transportation (PCPT)
8620 Galen Wilson Boulevard
Port Richey, Florida 34668

West (727) 834-3322
Central (813) 235-6073
East (352) 521-4587
Fax (727) 859-0589
TTY Access 7-1-1

Transportation Applicant:

Enclosed you will find a Pasco County Public Transportation (PCPT) Eligibility Application for Paratransit Services. To facilitate the review process, it will be necessary to determine your eligibility for Paratransit services. Therefore, the attached form must be completed and signed.

This form will be used to assess your transportation needs and to determine the most cost-effective mode of transportation for which you are eligible. You will be notified by PCPT of the review findings, within twenty-one (21) days of receipt of your completed application.

If you have any questions or concerns, please call the appropriate number above.

PCPT Staff

PASCO COUNTY PUBLIC TRANSPORTATION (PCPT)

**8620 Galen Wilson Boulevard
Port Richey, Florida 34668
(727) 834-3322**

FOR OFFICIAL PCPT USE ONLY

Eligible for ADA: _____
Eligible for TD _____
Eligible for III-B _____
Eligible for CDBG _____

ELIGIBILITY APPLICATION FOR PARATRANSIT SERVICES

First Name _____ Middle Initial _____ Last Name _____ Social Security # _____

Street Address _____ Apt # _____

City _____ State _____ County _____ Zip _____

Name of Condo/Apartment, Sub-Division or Mobile Home Park _____

Closest Major Intersection _____

Telephone (home) _____ (work) _____ Date of Birth _____ Sex (M) (F) _____

*The information below is optional and is used for statistical reporting purposes only. It is not used to determine eligibility for service.

*Race/Ethnicity: American Indian _____ Asian or Pacific Indian _____ Black, Not Hispanic Origin _____
Hispanic _____ White, Not Hispanic Origin _____

* Any Cultural Considerations _____

*Marital Status _____

Household Yearly Income _____ Source of Income _____ Number in Household _____

Other Household Members _____ Name _____ Relationship _____ Age _____ Driv. Lic.(Y/N) _____ Type of Vehicle _____
(Please list each member)

Do you own a vehicle? Yes _____ No _____ Do you have a Driver's License? Yes _____ No _____
Type of vehicle (car/van, etc) _____ Does any member of your household own a vehicle? Yes _____ No _____
Do you have friends or family members in the County who can transport you? Yes _____ No _____ If not, why? _____

Please list all Hospitals, Doctors and Medical Facilities that you visit on a regular basis:

| <u>NAME OF HOSPITAL/DOCTOR/FACILITY</u> | <u>NUMBER OF TYPE OF TREATMENT</u> | <u>DESCRIBE MONTHLY VISITS</u> | <u>HOW YOU PREVIOUSLY GOT THERE</u> |
|---|------------------------------------|--------------------------------|-------------------------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

AVAILABILITY OF FEDERALLY FUNDED OR PUBLIC TRANSPORTATION

Yes / No

1. _____ Do you live on a bus route? What is the distance to the nearest bus stop? _____
2. _____ Have you used the bus system for transportation in the past?
3. _____ Do you have any limitations that would prevent you from using the bus system now?
If YES, please describe your limitations below. Be specific.

4. _____ Are you enrolled in any other programs that will pay for or provide transportation? If YES, please describe them below.

SPECIAL NEEDS

Please check or list any special needs, services or modes of transportation you require during transportation:

_____ Powered Wheelchair/Scooter _____ Manual Wheelchair _____ Walker _____ Cane

_____ Respirator/Portable Oxygen _____ Service Animal _____ Personal Care Attendant (PCA) _____ Cue Cards

Other: _____

- Are you able to transfer from your wheelchair to a car easily?
_____ Yes _____ No _____ Not Applicable

If yes: _____ Independently. _____ Only with assistance

- Wheelchair Dimensions _____ Combined weight of chair and passenger _____
Is wheelchair equipped with seat belts? _____ Yes _____ No
Other (please identify): _____

- Can you climb three 12-inch steps to board a bus that has handrails?
_____ Yes _____ No _____ Sometimes
If no or sometimes, please explain.

- Some bus trips may require you to get off one bus and onto another to complete your trip. Can you do this on your own? _____
 Yes _____ No _____ Sometimes _____
 If no or sometimes, please explain.

- _____ My disability prevents me from getting to the bus stop.
 _____ I could use the regular PCPT fixed route bus after receiving travel training.
 _____ I can use the regular PCPT fixed route bus under certain circumstances. Please explain.

- In case of an evacuation would you need transportation to a shelter? _____ Yes _____ No
 If so, call and register with the SPECIAL NEEDS ASSISTANCE POPULATION PROGRAM (SNAPP) at (727) 847-8956 or (352) 521-5137.

- Please provide the name, address and phone number of an **emergency contact person**:

- Is your health condition or disability temporary? _____ Yes _____ No
 If yes, expected duration until ____/____/____ (____ months)

- PCPT's regular bus drivers call out bus stops at major transfer and destination points and all major intersections. They will also call out special stops upon request. With this help, can you recognize the right stop and get off the bus when you need to? _____
 Yes _____ No _____ Sometimes _____
 If no or sometimes, please explain.

- Using a mobility aid, or on your own, how far are you able to travel without the assistance of another person?
 _____ 1/2 block (Less than 200 ft.) _____ 1 or 2 blocks (circle one) _____ 1/4 mile (3 blocks)
 _____ 1/2 mile (6 blocks) _____ 3/4 mile (9 blocks) _____ Other (please explain)

NOTE: If someone other than the applicant has completed this form please provide the appropriate information in the space below.

| | | | |
|-------------------|------|---------------------------|-----|
| Name | | Relationship to Applicant | |
| Address | City | State | Zip |
| Daytime Telephone | | | |

This information is available in an accessible format upon request. To request these formats, please contact PCPT.

I understand that the information obtained in this certification process will only be used by PCPT to determine eligibility for Paratransit services, and that this information will only be shared with other transit providers or transportation programs to facilitate travel and/or coordinate services. This information will be kept confidential and will NOT be utilized for any other purpose, unless so

authorized by the applicant in writing or unless otherwise ordered released by a court of law or equity. However, I understand that PCPT may need to contact an authorized professional to verify the information on this application regarding how my status prevents me from using the *PCPT* fixed route schedule bus system.

**Collection of Social Security Numbers Notice
(Program Participants)**

Florida Statute 119.071(5) and Title 42 Code of Federal Regulations, Section 435.910, require any agency that collects Social Security numbers to provide a written explanation to the individual of the reason for its collection.

Why is Pasco County Public Transportation collecting your Social Security Number?

Pasco County Public Transportation is collecting your Social Security number as part of its responsibility to determine transportation eligibility. We do this to assess transportation services that are funded by the state or federal government for which you may qualify.

The provision of your Social Security number is mandatory and your information will remain confidential and protected under penalty of law. We will not use or give out your Social Security number for any other reason, including referrals to other agencies, unless you have signed a separate form consenting to the release of information to another agency.

I understand and affirm that the information provided in this Application is truthful and accurate to the best of my knowledge, and authorize the release of this information to PCPT for the purpose of evaluating my eligibility to participate in the Paratransit services program. I understand that providing false or misleading information, or making fraudulent claims, or making false statements on behalf of others constitutes a felony under the laws of the State of Florida. I agree to notify the *PCPT* office of any changes in my status immediately and understand that this may affect my eligibility to use these services. I understand the reason why Pasco County Public Transportation collects my Social Security number.

Please sign and return with your CDBG Self-Certification form.

Applicant Signature _____

Date _____

DISABILITY VERIFICATION

Disability verification by a qualified professional does not guarantee eligibility, but it can play a major role in the eligibility determination process. It is important that any professional that verifies an individual's disability be familiar not only with that person's particular disability, but with the individual's ability or inability to travel on PCPT's regular fixed route bus system.

Please have the following Request for Verification of Disability form completed by one of the health care professionals listed below and return it with the completed application.

Licensed Physician (MD) Physical Therapist Occupational Therapist
Certified Rehabilitation Counselor Orientation and Mobility Specialist

I understand that this information is confidential and will not be shared with any other person or agency, with the possible exception of another transit provider or transportation program to facilitate travel in those areas. **PCPT may verify this information with the health care professional.**

PASCO COUNTY PUBLIC TRANSPORTATION
(PCPT)
8620 GALEN WILSON BOULEVARD
PORT RICHEY, FLORIDA 34668
(727) 834-3200

**REQUEST FOR VERIFICATION
OF DISABILITY**

Dear Medical Provider:

Patient Name: _____

This form is necessary for the above named patient to utilize our transit services. He/she has indicated that you can verify his/her disability and its impact upon his/her ability. Federal law (the Americans with Disabilities Act of 1990) requires Pasco County Public Transportation (PCPT) to provide Paratransit services to persons who cannot utilize available fixed route services. The information you provide will allow us to make an appropriate evaluation of this request and its application to specific trip requests. Thank you for your cooperation in this matter.

NOTE: Disability verification is mandatory for all applicants for PCPT service. Any professional that verifies an individual's disability, must have detailed, first-hand knowledge of that person's disability, as well as the training and credentials necessary for such an evaluation.

- Please describe your professional status; i.e., Licensed Physician, Physical Therapist, Occupational Therapist, Specialist and describe your methods for evaluating the applicant's disability.

- Medical/functional condition causing the disability, which will prevent the individual from using the regular bus service.

- Is this condition temporary? Yes No

If yes, expected duration until ____/____/____

PHYSICAL DISABILITIES

- If the person has a disability affecting mobility, is the person able to travel either on his/her own or with a mobility aid 200 feet without the physical assistance of another person?
 Yes No Sometimes
- Is the person able to travel either on his/her own or with a mobility aid 200 yards without the physical assistance of another person?
 Yes No Sometimes
- Is the person able to travel either on his/her own or with a mobility aid ¼ mile without the physical assistance of another person?
 Yes No Sometimes
- Is the person able to climb three (3) 12-inch steps without the assistance of another person? (Handrails are available)
 Yes No Sometimes
- Is the person able to wait outside without support for ten (10) minutes?
 Yes No Sometimes
- Does this person require special assistance and /or the use of any mobility aids? If so, what?

- Are there any circumstances in which the applicant could not ride the regular, lift-equipped PCPT buses? Please describe.

- Does this person require a Personal Care Attendant (PCA) when traveling on public transit?
 Yes No Sometimes (describe)

- If this person falls, can he/she get up independently? Yes No Sometimes
- Can this person negotiate traffic safely and independently? Yes No Sometimes
- Can this person read information signs? Yes No
If no, please explain.

- **NOTE: PCPT must be made aware of any special requirements of eligible passengers particularly if traveling with a respirator or portable oxygen supply. Please describe if applicable.**

- If there is any other effect of the disability of which PCPT should be aware, please describe (e.g., heat sensitivity, etc.).

Name of Professional

Mailing Address

City State Zip

Telephone Number

Signature: _____ Date: _____



PASCO COUNTY CDBG PROGRAM ADMINISTRATION

Self-Certification Form for Eligibility of Service

The information requested below is required to determine if you are eligible for the service or program, funded with Community Development Block Grant (CDBG) funds, disbursed by the US Department of Housing and Urban Development (HUD).

Information provided in this form is strictly confidential and will not be released to anyone other than the Pasco County CDBG Program Administrator and Pasco County Public Transportation ([PCPT](#)) staff responsible for collecting this information.

Any questions call PCPT (727) 834-3322, (813) 235-6073 or (352) 521-4587.

1. Name of Applicant: _____

2. Street Address: _____

3. City: _____

4. State: _____

5. Zip: _____

6. County of Residence: _____

7. Number of Persons in your household including yourself:

| # of Adults in Household | # of Children in Household | # of Elderly in Household | # of Disabled in Household | TOTAL # OF PERSONS IN HOUSEHOLD |
|--------------------------|----------------------------|---------------------------|----------------------------|---------------------------------|
| | | | | |
| | | | | |

8. Total household income (adjusted gross income) earned by all adults 18 years and older?

| Income Source | Total Yearly Income | Total Monthly Income | Total Weekly Wages | No Income |
|---------------|---------------------|----------------------|--------------------|-----------|
| | | | | |
| | | | | |

9. Ethnicity (select only one):

| Ethnicity | Select one |
|----------------------------|--------------------------|
| Hispanic or Latino | <input type="checkbox"/> |
| Non-Hispanic or Non-Latino | <input type="checkbox"/> |

10. Race (select only one):

| Race | Select one |
|---|--------------------------|
| White | <input type="checkbox"/> |
| Black / African American | <input type="checkbox"/> |
| Asian | <input type="checkbox"/> |
| American Indian/Alaskan Native | <input type="checkbox"/> |
| Native Hawaiian or Other Pacific Islander | <input type="checkbox"/> |
| White & Asian | <input type="checkbox"/> |
| White & Black/African American | <input type="checkbox"/> |
| Black/African American & American Indian/Alaskan Native | <input type="checkbox"/> |
| Other Multiracial | <input type="checkbox"/> |



PASCO COUNTY CDBG PROGRAM ADMINISTRATION

Self-Certification Form for Eligibility of Service

11. Do you or any of your household members belong to one or more of the following categories?

| Special Needs Categories | Check applicable box(es) | Person(s) in Category |
|--|--------------------------|-----------------------|
| Elderly Person (62 years or older): | <input type="checkbox"/> | |
| Homeless: | <input type="checkbox"/> | |
| Disabled: | <input type="checkbox"/> | |
| Severely Disabled: | <input type="checkbox"/> | |
| Illiterate: | <input type="checkbox"/> | |
| Battered Spouse: | <input type="checkbox"/> | |
| Abused Minor: | <input type="checkbox"/> | |
| AIDS Patient: | <input type="checkbox"/> | |
| Migrant Farm Worker: | <input type="checkbox"/> | |
| Part of female-headed Household: (where the primary wage-earner is a woman): | <input type="checkbox"/> | |
| TOTAL PERSONS LIVING IN HOUSEHOLD | | |

I hereby certify that the above information is true and correct to the best of my knowledge. I understand that any benefit received by me or my household through Community Development Block Grant (CDBG) funds is contingent upon meeting the above eligibility requirements. I also understand that this information may be verified, and I authorize the release of any information required to verify this information. If this information cannot be verified as true and correct, I understand that it may exclude me and/or my household for receiving the above mentioned service. I may be required to repay funds received through the CDBG program administration if I fail to provide true and correct information to qualify me or my household for this program.

Signature

Date



FY 2015 INCOME LIMITS DOCUMENTATION SYSTEM

HUD.gov [HUD User Home Data Sets](#) [Fair Market Rents](#) [Section 8 Income Limits](#) [MTSP Income Limits](#) [HUD LIHTC Database](#)

FY 2015 Income Limits Summary

| FY 2015 Income Limit Area | Median Income Explanation | FY 2015 Income Limit Category | Persons in Family | | | | | | | |
|---------------------------|-------------------------------------|---|-------------------|--------|--------|---------------|--------|--------|---------|---------|
| | | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| Pasco County | \$59,000 | Very Low (50%) Income Limits (\$) Explanation | 20,650 | 23,600 | 26,550 | 29,500 | 31,900 | 34,250 | 36,600 | 38,950 |
| | | Extremely Low Income Limits (\$)* Explanation | 12,400 | 15,930 | 20,090 | 24,250 | 28,410 | 32,570 | 36,600* | 38,950* |
| | | Low (80%) Income Limits (\$) Explanation | 33,050 | 37,800 | 42,500 | 47,200 | 51,000 | 54,800 | 58,550 | 62,350 |