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 Team

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

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:

NAME OF HOSPITAL/DOCTOR/FACILITY	NUMBER OF TYPE OF TREATMENT	DESCRIBE MONTHLY VISITS	HOW YOU PREVIOUSLY GOT THERE
______________________	_________________	________________	________________________
______________________	_________________	________________	________________________
______________________	_________________	________________	________________________
______________________	_________________	________________	________________________

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?
  _____½ block (Less than 200 ft.) _____1 or 2 blocks (circle one) _____¼ mile (3 blocks)
  _____½ mile (6 blocks) _____¾ 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 _____________________

Health Insurance Portability and Accountability Act (HIPAA) and Privacy Practices

The HIPAA and Privacy Practices notice is provided with this application. It shall be the policy of PCPT to safeguard and keep confidential, all information about clientele of any service within its purview. This policy will apply to both written and oral communication, and will include personal and/or medical information. 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.**

This is to certify that I have read, understood, and received a copy of the above notice.

Applicant Signature ________________________________ Date _____________________________

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

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 <u>200 feet</u> 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 <u>200 yards</u> 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 <u>¼ mile</u> 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 <u>must</u> 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	☐
Non-Hispanic or Non-Latino	☐

10. Race (select only one):

Race	Select one
White	☐
Black / African American	☐
Asian	☐
American Indian/Alaskan Native	☐
Native Hawaiian or Other Pacific Islander	☐
White & Asian	☐
White & Black/African American	☐
Black/African American & American Indian/Alaskan Native	☐
Other Multiracial	☐

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):	☐	
Homeless:	☐	
Disabled:	☐	
Severely Disabled:	☐	
Illiterate:	☐	
Battered Spouse:	☐	
Abused Minor:	☐	
AIDS Patient:	☐	
Migrant Farm Worker:	☐	
Part of female-headed Household: (where the primary wage-earner is a woman):	☐	
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 2014 Income Limits Documentation System

HUD.gov/HUD User Home
Section 8 Income Limits

FY 2014 Income Limits Summary

FY 2014 Income Limit Area Median Income	FY 2014 Income Limit Category	Persons in Family 1	2	3	4	5	6	7	8
Pasco County $57,400	**Very Low (50%)**	20,100	23,000	25,850	28,700	31,000	33,300	35,600	37,900
	Extremely Low (30%)	12,050	13,800	15,500	17,200	18,600	20,000	21,350	22,750
	Low (80%)	32,150	36,750	41,350	45,900	49,600	53,250	56,950	60,600

NOTE: Pasco County is part of the Tampa-St. Petersburg-Clearwater, FL MSA, so all information presented here applies to all of the Tampa-St. Petersburg-Clearwater, FL MSA. The Tampa-St. Petersburg-Clearwater, FL MSA contains the following areas: Hernando County, FL; Hillsborough County, FL; Pasco County, FL; and Pinellas County, FL. Selecting any of the buttons labeled "Click Here" will display detailed calculation steps for each of the various parameters.
Income Limit areas are based on FY 2014 Fair Market Rent (FMR) areas. For information on FMRs, please see our associated FY 2014 Fair Market Rent documentation system. For last year's Median Family Income and Income Limits, please see here:

http://www.huduser.org/portal/datasets/il/il2014/2014summary.odn