

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

Date: \_\_\_\_\_

Dear Transportation Applicant:

Enclosed you will find a Pasco County Public Transportation (PCPT) application for Paratransit services. Please complete the attached application, sign and mail the application back to PCPT at the address on the form.

PCPT will use this form to assess your transportation needs and to determine your eligibility for transportation within our various transportation opportunities. PCPT will notify you of the review findings, within twenty-one (21) days of receipt of your completed application.

If you do not receive any response within 20-days you returning this application, please contact PCPT at 727-834-3322 to follow up on your application.

If you have any questions or concerns, please call PCPT at 727-834-3322.

Respectfully,

Kurt M. Scheible  
Public Transportation Director

**PUBLIC SERVICES BRANCH**

**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.

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- \_\_\_\_\_ 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.

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- 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**:

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- 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.

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- 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)

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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.**

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

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**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"/>	
<b>TOTAL PERSONS LIVING IN HOUSEHOLD</b>		

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](http://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 <b>Explanation</b>	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 (\$) <b>Explanation</b>	20,650	23,600	26,550	<b>29,500</b>	31,900	34,250	36,600	38,950
		Extremely Low Income Limits (\$)* <b>Explanation</b>	12,400	15,930	20,090	<b>24,250</b>	28,410	32,570	36,600*	38,950*
		Low (80%) Income Limits (\$) <b>Explanation</b>	33,050	37,800	42,500	<b>47,200</b>	51,000	54,800	58,550	62,350

## **Health Insurance Portability and Accountability Act (HIPAA)**

Pasco County Public Transportation (PCPT) and the contract providers will comply with all requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996's Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule"). As such, each agrees to the following:

- A. That neither party will use or disclose protected health information for any purpose other than as authorized by law, by this contract, or by separate agreement between the parties.
- B. That each party will not use or disclose protected health information in a manner which would be a prohibited use or disclosure if made by the other.
- C. That each party will maintain safeguards as necessary to ensure that the protected health information is not used or disclosed except as provided by law, by this contract, or by separate agreement between the parties.
- D. That each party will report to the other any use or disclosure of the protected health information of which it becomes aware that is not provided for by law, by this contract, or by separate agreement between the parties.
- E. That each party will ensure that any of its subcontractors or agents to whom it provides protected health information received from the other agree to the same restrictions and conditions that apply to each other with respect to such information.
- F. That each party will follow an agreed upon process established to provide access to protected health information to the subject of that information when the other has made any material alteration to the information. This process will include how each party would determine in advance how the other would know or could readily ascertain when a particular individual's protected health information has been materially altered by the other and how it could provide access to such information. This process will establish how each party would provide access to protected health information to the subject of the information in circumstances where the information is being held by the other.
- G. That each party will provide health information to the subject of the information in accordance with the subject's right to access, inspect, copy, and amend their health information.
- H. That each party will make available to the other its internal practices, books and records relating to the use, disclosure, and tracking of disclosure of protected health information received from the other or its agents for the purposes of enforcing compliance with HIPAA.

- I. That each party will assist the other in meeting its obligation to provide, at an individual's request, an accounting of all uses and disclosures of personal health information which are not related to treatment, payment, or operations within sixty (60) days of the request of an accounting.
- J. That each party will incorporate any amendments or corrections to protected health information when notified by the other that the information is inaccurate or incomplete.
- K. That at the termination of this contract, unless a new contract is agreed upon, each party will return or destroy all protected health information received from the other that it still maintains in any form.
- L. That either party may terminate this contract if it learns that the other has repeatedly violated a term of this contract provision.
- M. That each party will disclose only the minimum amount of information necessary to accomplish the permitted use of the protected health information. This minimum use requirement does not apply to information provided for treatment or to disclosures required by law.
- N. That each party will limit the use and disclosure of protected health information to the minimum number of employees necessary by class of employee and type of information to accomplish the permitted use of the information.
- O. That each party will meet at least the minimum security requirements for the protection of protected health information as required by HIPAA.
- P. That each party is bound by the terms of the "Notice of Practices" of the other with regard to protected health information it receives from the other.