

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 contact PCPT.

Respectfully,

Kurt M. Scheible
Public Transportation Director

PUBLIC SERVICES BRANCH

727.834.3322 | Pasco County Public Transportation | 8620 Galen Wilson Boulevard | Port Richey,
FL 34668

PASCO COUNTY PUBLIC TRANSPORTATION (PCPT)

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

FOR OFFICAL PCPT USE ONLY	
Eligible for ADA	_____
Eligible for TD	_____
Eligible for III-B	_____

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	Driver's License(Y/N)	Vehicle Type
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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 _____ Cane _____
- Manual Wheelchair _____ Respirator/Portable Oxygen _____
- Walker _____ 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.

- If you need transportation to a shelter in the case of an emergency; please contact Pasco County Customer Service to register. The contact phone numbers are as follows; (727)-847-2411, (352)-523-2411 or (813)-996-2411.
- 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	Daytime Telephone
Address		City	State Zip

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.

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 _____

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

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 1/4 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: _____