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
ELIGIBILITY APPLICATION FOR PARATRANSIT SERVICES

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Initial</th>
<th>Last Name</th>
<th>Social Security #</th>
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<tr>
<th>Street Address</th>
<th>Apt #</th>
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<tr>
<td>City</td>
<td>State</td>
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Name of Condo/Apartment, Sub-Division or Mobile Home Park

Closest Major Intersection

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<tr>
<th>Telephone (home)</th>
<th>(work)</th>
<th>Date of Birth</th>
<th>Sex (M) (F)</th>
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*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)

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Age</th>
<th>Driver’s License (Y/N)</th>
<th>Vehicle Type</th>
</tr>
</thead>
</table>

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:

<table>
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<tr>
<th>NAME OF HOSPITAL/DOCTOR/FACILITY</th>
<th>NUMBER OF MONTHLY VISITS</th>
<th>TYPE OF TREATMENT</th>
<th>PREVIOUSLY GOT THERE</th>
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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?  
_____ 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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to Applicant</th>
<th>Daytime Telephone</th>
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<tbody>
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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.
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

- 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: ___________________