



# PASCO COUNTY PUBLIC TRANSPORTATION

## Americans with Disabilities Act (ADA) Paratransit Application

### INSTRUCTIONS FOR COMPLETING THE ELIGIBILITY APPLICATION PROCESS

Please fill out the application completely, sign all the pages requiring a signature, and return it by mail to the address below.

Approved riders **age 14 and older** may travel alone. Approved riders **age 13 and younger** and all riders with special medical needs must travel with a Personal Care Attendant (PCA). A PCA is an adult designated to help the applicant with their daily living needs. Pasco County Public Transportation (PCPT) does not provide a PCA. If the applicant needs a PCA, please indicate so on the application.

Applicants may be required to attend an in-person functional assessment at a designated facility. If required, the applicant will be instructed how to complete the assessment. If an applicant does not have transportation to the assessment, PCPT will provide it. After receiving the completed application, PCPT will determine eligibility within 21 calendar days. Eligibility results will be sent to the applicant by mail. After 21-day, presumptive eligibility will be granted while the application process is completed.

**Disability Verification** by a qualified professional does not guarantee eligibility approval. It does play a major role in the eligibility determination process, though. The Florida licensed healthcare professional most familiar with the applicant's medical history should complete and sign Form A: General Medical Verification. **The medical professional must be able to determine the applicant's ability or inability to navigate PCPT's regular fixed route bus system.** Qualified medical professionals include: Licensed Physicians (MD), Certified Rehabilitation Counselors, Physical Therapists, Occupational Therapists, or Orientation and Mobility Specialists. PCPT may verify information provided by the healthcare professional.

PCPT offers other Paratransit services based on an applicant's age, income, and access to transportation. To ensure the applicant receives all the services they qualify for, please complete the PCPT ADA Paratransit Application and Form E Application for Other Paratransit Services.

All information provided to PCPT is confidential and will not be shared with any other person or agency without written consent. For additional information, call PCPT at **(727) 834-3322** or visit [www.ridepcpt.com](http://www.ridepcpt.com). Please mail the completed application to:

**Pasco County Public Transportation (PCPT)**

**8620 Galen Wilson Boulevard**

**Port Richey, FL 34668**

**Pasco County Public Transportation**

727.834.3322 | 8620 Galen Wilson Boulevard | Port Richey, FL 34668

# PCPT ADA Paratransit Application

Received: _____ <small>MM/DD/YYYY</small>	Processed: _____ <small>MM/DD/YYYY</small>
Closest Bus Stop: _____ <small>FEET</small>	ADA Category 1 2 3 PCA H2H <small>CIRCLE ALL THAT APPLY</small>
Equipment: _____	ADA Conditions: _____
Reviewed By: _____	On: _____ <small>MM/DD/YYYY</small>
Approved for: <input type="checkbox"/> ADA <input type="checkbox"/> TD <input type="checkbox"/> III-B	
Approved: _____ <small>MM/DD/YYYY</small>	Expires: _____ <small>MM/DD/YYYY</small>

Client ID #: \_\_\_\_\_  New Applicant  Recertification

## PART 1 GENERAL INFORMATION

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apartment: \_\_\_\_\_

Facility, Subdivision, or Community Name: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Male  Female  Other

Primary Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Pasco Residency:  Full Time  Part Time  Temporary

Emergency Contact (Required): \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

### If someone assisted the applicant with this form, please provide:

Name: \_\_\_\_\_ Primary Phone: \_\_\_\_\_

Is applicant a United States veteran?  Yes  No

Veterans ride free on PCPT ADA Paratransit service. To report veteran status, attach a copy of one of the following identification cards to this application (check ID used):

Military ID Card  DD Form 2  VA Card  State ID marked "V"

*\*This information is optional, used only for statistical reporting purposes; it is not used to determine eligibility for services. Check all that apply and fill in the blanks:*

American Indian  Asian  Black  Hispanic  Pacific Island  White

Marital Status: \_\_\_\_\_ Cultural Considerations: \_\_\_\_\_

# PCPT ADA Paratransit Application

## HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AND PRIVACY POLICY

It is the policy of PCPT to safeguard and keep confidential all information about any applicant or client of any service offered by PCPT. This policy applies to any written, verbal, electronic, or other communications between PCPT and any applicant or client. This policy applies to both personal and medical information. PCPT will only give employees access to this information when they need it to make an eligibility requirement, provide paratransit service to the applicant, or when fulfilling regulatory reporting requirements.

The applicant acknowledges that PCPT will not share the applicant's personal and medical information with any person or agency without their express written consent. PCPT may verify the information provided in this application with the healthcare professional providing it.

*By signing below, I acknowledge that I have read, understand, and received a copy of this notice.*

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*If the applicant is unable to sign any document in this application, the applicant's power of attorney may sign for the applicant and must provide proof of their power of attorney.*

## PART 2 INFORMATION ABOUT APPLICANT'S DISABILITY

1. Please checkoff all conditions that prevent the applicant from independently riding PCPT's fixed route service. The applicant's healthcare provider will complete *Form A General Medical Verification*, verifying the conditions checked below.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Arteriosclerosis               | <input type="checkbox"/> Heart Attack             | <input type="checkbox"/> Paraplegia                  |
| <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Hearing Impairment       | <input type="checkbox"/> Parkinson's Disease         |
| <input type="checkbox"/> Cancer                         | <input type="checkbox"/> HIV/ AIDS                | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Cerebral Palsy                 | <input type="checkbox"/> Intellectual Disability  | <input type="checkbox"/> Quadriplegia                |
| <input type="checkbox"/> COPD                           | <input type="checkbox"/> Kidney Disease/ Dialysis | <input type="checkbox"/> Stroke/ Cerebral Trauma     |
| <input type="checkbox"/> Cognitive Defect               | <input type="checkbox"/> Lupus                    | <input type="checkbox"/> Thrombosis                  |
| <input type="checkbox"/> Congestive Heart Failure       | <input type="checkbox"/> Mental Illness           | <input type="checkbox"/> Visual Impairment           |
| <input type="checkbox"/> Epilepsy/ Seizures             | <input type="checkbox"/> Multiple Sclerosis       |  |
| <input type="checkbox"/> Surgery: Date _____ Type _____ |   |  |
| <input type="checkbox"/> Other: _____                   | <input type="checkbox"/> Other: _____             |  |

# PCPT ADA Paratransit Application

2. Check all mobility aids or medical devices used by the applicant:

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Oxygen                          | <input type="checkbox"/> Crutches          | <input type="checkbox"/> White Cane   |
| <input type="checkbox"/> Cane                            | <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Cue Cards    |
| <input type="checkbox"/> Leg Braces                      | <input type="checkbox"/> Power Wheelchair  | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Walker                          | <input type="checkbox"/> Power Scooter     | _____                                 |
| <input type="checkbox"/> Service Animal, Describe: _____ |  |                                       |

3. A **Personal Care Attendant (PCA)** is a responsible adult who helps another person with their **Activities of Daily Living (ADLs)**, including travel. PCAs are always allowed to travel with an eligible client free of charge when a medically justifiable need is established. PCPT will not provide the applicant a PCA, nor will PCPT drivers help clients with their ADLs. Does the applicant require the assistance of a PCA?

Yes, a PCA is needed to help the applicant with (check all that apply):

- |                                       |                                     |  |
|---------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Mobility     | <input type="checkbox"/> Transfers  | <input type="checkbox"/> Decision Making |
| <input type="checkbox"/> Reading      | <input type="checkbox"/> Navigation | <input type="checkbox"/> Medication      |
| <input type="checkbox"/> Other: _____ |                                     |  |

No, the applicant does not need a PCA.

## PART 3 QUESTIONS ABOUT USING PCPT FIXED-ROUTE BUSES

1. Has the applicant ever used PCPT's Fixed Route buses?  Yes  No
2. If yes, enter the date the applicant last rode a PCPT Fixed Route bus: \_\_\_\_\_
3. How many times has the applicant used a PCPT Fixed Route bus during the last year?  Never  1-12 Times  12-50 Times  Over 50 Times
4. If the applicant was riding PCPT's Fixed Route service and has since stopped, explain why: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## PCPT ADA Paratransit Application

5. What will help the applicant ride a PCPT Fixed Route bus? (*check all that apply*)

Communication aids.

Route and schedule information.

Being taught how to travel on the buses.

Having bus stops closer to home and destinations.

Other: \_\_\_\_\_

Nothing can help the applicant ride PCPT's Fixed Route service.

6. Can the applicant ask for and follow written and/ or oral instructions to use a PCPT Fixed Route bus?     Yes     No     Sometimes

If the answer is *No* or *Sometimes*, check all that apply:

Applicant probably could ride bus if someone taught them how.

Other people cannot understand the applicant.

The applicant might get confused or lost riding the bus.

Other: \_\_\_\_\_

7. Can the applicant go to bus stops alone?     Yes     No     Sometimes

If the answer is *No* or *Sometimes*, check all that apply:

Applicant probably could ride bus if someone taught them how.

Applicant gets confused and cannot find their way.

Applicant cannot travel outside when it is too hot.

Applicant cannot use streets or sidewalks that are too steep.

Applicant cannot cross busy streets and intersections.

Applicant cannot get to places without curb-cuts.

Applicant cannot see well at night.

Other: \_\_\_\_\_

# PCPT ADA Paratransit Application

8. How far can the applicant travel on their own, with or without using a mobility aid device?

- Unable to leave residence alone.
- Able to travel from residence to front curb or driveway.
- Able to travel from residence to nearest bus stop.

9. Can the applicant wait outside up to 30 minutes for a PCPT Fixed Route bus?

- Yes
- Yes, if they can sit
- Yes, if there is shelter
- No

10. Can the applicant use a ramp or lift to board a PCPT Fixed Route bus?

- Yes
- No
- Sometimes
- I don't know

If *No* or *Sometimes* is checked, explain why: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. Once onboard a PCPT Fixed Route bus, can the applicant get to a seat or wheelchair position without help?

- Yes
- No
- Sometimes
- I don't know

If *No* or *Sometimes* is checked, explain why: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. If the applicant can board a PCPT Fixed Route bus, will they know where to get off the bus and can they find their way to their destination without assistance?

- Yes
- No
- Sometimes
- I do not know

If *No* or *Sometimes* is checked, explain why: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# PCPT ADA Paratransit Application

13. Are there any other reasons why the applicant cannot ride a PCPT Fixed Route bus? Please check all that apply:

Too much traffic     No crosswalks     No traffic lights to cross street

No curb cuts     No or poor sidewalks     Road construction

Too far to walk     Cannot be in cold or hot weather over 30 minutes

Other reason: \_\_\_\_\_

14. If the applicant cannot tolerate cold or hot weather, state the coldest and warmest temperature they can tolerate, how long, and why: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

15. Provide the names and address of places the applicant routinely goes to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16. Provide other relevant information about the applicant that has not been asked:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# PCPT ADA Paratransit Application

## **PART 4 COLLECTION OF SOCIAL SECURITY NUMBERS NOTICE (PROGRAM PARTICIPANTS)**

Florida Statute 119.071(5) and Title 42 of the Code of Federal Regulations, Section 435.910 requires an agency collecting Social Security Numbers to provide a written explanation why they are collecting the Social Security Number.

### **Why is Pasco County Public Transportation collecting the applicant's Social Security Number?**

Pasco County Public Transportation is collecting the applicant's Social Security Number as part of its responsibility to determine transportation eligibility. PCPT does this to assess the applicant's eligibility for transportation services funded by state or federal government.

### **The provision of the applicant's Social Security Number is mandatory, and the applicant's information will remain confidential and protected under penalty of law.**

PCPT will not use or give out the applicant's Social Security Number for any reason other than to determine the applicant's eligibility for transportation services. PCPT will not give the applicant's Social Security Number to other agencies unless the applicant has signed a separate form consenting to the release of information to another agency.

### **Affidavit:**

*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 PCPT of any changes in my status immediately and understands 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's Social Security Number: \_\_\_\_\_

\_\_\_ *By checking this statement, I state that I refuse to provide my Social Security Number. I understand that I will not be considered for any Paratransit service that requires a Social Security Number. I would like to be considered for other services that do not require one and have completed Form E Application for Other Paratransit Services.*

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*If the applicant is unable to sign, the applicant's power of attorney may sign for the applicant and must provide proof of their power of attorney.*

# PCPT ADA Paratransit Application

## **PART 5 APPLICANT CERTIFICATION**

By signing below, the applicant affirms the information provided in the Application is correct to the best of their knowledge.

### **Affidavit:**

*I understand the purpose of this application is to help PCPT determine if there are times when I cannot use the PCPT fixed route bus service and must use Paratransit services. I certify, to the best of my knowledge, that the information in this application is true and correct. I understand that providing false or misleading information or making false statements on behalf of others constitutes fraud, is considered a felony under the laws of the State of Florida and may result in a reevaluation or revocation of my eligibility.*

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*If the applicant is unable to sign, the applicant's power of attorney may sign for the applicant and must provide proof of their power of attorney.*

Please attach a copy of the applicant's valid government photo identification to this application. Acceptable forms include a state issued driver's license, a state issued identification card, a U.S. military issued identification card, or a passport.

## **PART 6 APPLICANT MEDICAL INFORMATION RELEASE AUTHORIZATION**

*By signing below, I give permission to my Healthcare Provider(s) to release my medically protected information to Pasco County Public Transportation, for the sole purpose of determining my eligibility to receive PCPT Paratransit services.*

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*If the applicant is unable to sign, the applicant's power of attorney may sign for the applicant and must provide proof of their power of attorney.*

# PCPT ADA Paratransit Application

## **PART 7 PCPT PARATRANSIT ELIGIBILITY MEDICAL VERIFICATION FORMS**

Please ask the applicant's Florida Licensed or Certified Healthcare Provider to complete the medical form that best describes the applicant's need for Paratransit services.

### **Note to Healthcare Provider:**

*By completing and signing the Paratransit Eligibility Medical Verification Forms, the healthcare provider certifies the truth and accuracy of the information provided on the application, to the best of their professional knowledge. The Americans with Disabilities Act of 1990 requires PCPT to provide services to persons who are unable to use PCPT's Fixed Route bus service due to a disability. The information the healthcare provider allows PCPT to make an appropriate evaluation of the applicant's eligibility.*

To qualify for Paratransit services, an individual must meet the criteria as set forth in one of the following categories:

1. Individuals who, as a result of a physical or mental impairment (including visual impairments) and without the assistance of another individual (except the bus operator), cannot board, ride, or disembark from an accessible transit bus or vehicle.
2. Individuals who can independently use an accessible transit bus or vehicle, but none are available on their route (all PCPT buses are ADA compliant).
3. Individuals who have a specific impairment-related condition that prevents them from getting to or from a posted PCPT Fixed Route bus stop.

Anyone applying for ADA Paratransit service must submit Form A: General Medical Verification. Applicants may, but are not required, to submit the following forms as well:

- Form B Visual Impairment Verification
- Form C Epilepsy or Seizure Disorders Verification
- Form D Cognitive or Mental Health Conditions Verification

All applicants should complete Form E Application for Other Paratransit Services. The more services an applicant qualifies for, the more flexibility they have when riding a PCPT Paratransit service.

Please attach all original signed Medical Verification Forms to this Application before submitting to Pasco County Public Transportation for an eligibility determination.

# PCPT ADA Paratransit Application

## Form A General Medical Verification

The Florida licensed healthcare professional most familiar with the applicant's medical history should complete and sign this form. ***The medical professional must be able to determine the applicant's ability or inability to navigate Pasco County Public Transportation's (PCPT) Fixed Route bus system.*** Qualified medical professionals include:

- Licensed Physicians (MD)
- Certified Rehabilitation Counselors
- Physical Therapists
- Occupational Therapists
- Orientation and Mobility Specialists.

Please explain how the applicant's disability prevents them from using PCPT's Fixed Route bus service independently. To learn more about PCPT's service, please visit [ridepcpt.com](http://ridepcpt.com) or call [727-834-3322](tel:727-834-3322) to speak with a representative.

Please note, all PCPT fixed route buses are 100% accessible to people with disabilities as required by Federal Transit Authority Circular 4710.1 Americans With Disabilities Act (ADA): Guidance. This document can be found at:

[https://www.transit.dot.gov/sites/fta.dot.gov/files/docs/Final\\_FTA\\_ADA\\_Circular\\_C\\_4710.1.pdf](https://www.transit.dot.gov/sites/fta.dot.gov/files/docs/Final_FTA_ADA_Circular_C_4710.1.pdf).

Applicants Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. Date of onset of qualifying disability or medical condition: \_\_\_\_\_

2. Is applicant's functional limitation permanent?    \_\_\_ Yes    \_\_\_ No

If No, what is the expected duration (years and/ or months): \_\_\_\_\_

PCPT will not provide a Personal Care Attendant (PCA), nor will PCPT drivers help clients with their Activities of Daily Living. Does the applicant need a PCA to safely ride a PCPT Paratransit vehicle?    \_\_\_ Yes    \_\_\_ No    If Yes, explain why: \_\_\_\_\_

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PCPT ADA Paratransit Application  
Form A General Medical Verification

PCPT Paratransit provides door-to-door service. We will pick up a client at a departure point door, drive to a destination, then deliver them to the destination door. Our drivers do assist passengers on to and off the vehicles, which includes securing wheelchairs and other mobility devices and stowing packages. Drivers do not enter buildings or contact on-sight staff members on behalf of the client.

Can the applicant safely be left unattended at a pickup or drop-off locations

Yes     No    If No, explain why: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please provide any other information that may help PCPT determine the applicant's eligibility for Paratransit service: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*I certify the information provided above is correct.*

\_\_\_\_\_  
Signature of Licensed Healthcare Provider

\_\_\_\_\_  
Date

Please print your contact information below:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_

Florida Board Certificate or License Number: \_\_\_\_\_

**PCPT ADA Paratransit Application**  
**Form B Visual Impairment Verification**

Please explain how the applicant's visual impairment prevents them from using PCPT's Fixed Route bus service independently.

Applicants Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. Please state applicant's Visual Impairment: \_\_\_\_\_

2. Corrected Visual Acuity: OS \_\_\_\_\_ OD \_\_\_\_\_

3. Date of onset: \_\_\_\_\_

4. Is applicant's functional limitation permanent? \_\_\_ Yes \_\_\_ No

If No, what is the expected duration (years and/ or months): \_\_\_\_\_

5. Explain how the applicant's visual disability, combined with any environmental barriers, prevents their independent use of PCPT's Fixed Route bus service:

\_\_\_\_\_  
\_\_\_\_\_

6. PCPT will not provide a Personal Care Attendant (PCA), nor will PCPT drivers help clients with their Activities of Daily Living. Does the applicant need a PCA to safely ride a PCPT Paratransit vehicle? \_\_\_ Yes \_\_\_ No If Yes, explain why:

\_\_\_\_\_  
\_\_\_\_\_

7. PCPT Paratransit drivers do not enter buildings or contact on-sight staff members on behalf of a client. Can the applicant safely be left unattended at pickup or drop-off locations? \_\_\_ Yes \_\_\_ No If No, explain why: \_\_\_\_\_

\_\_\_\_\_

*I certify the information provided above is correct.*

\_\_\_\_\_  
Signature of Licensed Healthcare Provider \_\_\_\_\_ Date \_\_\_\_\_

Please print your contact information: Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Business Address: \_\_\_\_\_

Florida Board Certificate or License Number: \_\_\_\_\_

# PCPT ADA Paratransit Application

## Form C Epilepsy or Seizure Disorders Verification

Please explain how the applicant's epilepsy or seizure disorder prevents them from using PCPT's Fixed Route bus service independently.

Applicants Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. Type of Seizure: \_\_\_\_\_ Frequency: \_\_\_\_\_

2. Does the seizure alter consciousness or awareness?  Yes  No

3. Is applicant's functional limitation permanent?  Yes  No

If No, what is the expected duration (years and/ or months): \_\_\_\_\_

4. Explain the behaviors exhibited by the applicant during and following a seizure:

\_\_\_\_\_  
\_\_\_\_\_

5. Would applicant be able to travel independently on fixed-route buses if they are medication compliant?  Yes  No

6. PCPT will not provide a Personal Care Attendant (PCA), nor will PCPT drivers help clients with their Activities of Daily Living. Does the applicant need a PCA to safely ride a PCPT Paratransit vehicle?  Yes  No If Yes, explain why:

\_\_\_\_\_  
\_\_\_\_\_

7. PCPT Paratransit drivers do not enter buildings or contact on-sight staff members on behalf of a client. Can the applicant safely be left unattended at pickup or drop-off locations?  Yes  No If No, explain why: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

*I certify the information provided above is correct.*

\_\_\_\_\_  
Signature of Licensed Healthcare Provider

\_\_\_\_\_  
Date

Please print your contact information: Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Business Address: \_\_\_\_\_

Florida Board Certificate or License Number: \_\_\_\_\_

# PCPT ADA Paratransit Application

## Form D Cognitive or Mental Health Conditions Verification

Please explain how the applicant's cognitive or mental health prevents them from using PCPT's Fixed Route bus service independently.

Applicants Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. Applicant's DSM-5 diagnoses: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

2. Does the disability alter consciousness or awareness?  Yes  No

3. Is applicant's functional limitation permanent?  Yes  No

If No, what is the expected duration (years and/ or months): \_\_\_\_\_

4. Check any of the following that is affected by the individual's disability:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Orientation     | <input type="checkbox"/> Concentration     | <input type="checkbox"/> Monitoring Time  |
| <input type="checkbox"/> Problem Solving | <input type="checkbox"/> Coping Skills     | <input type="checkbox"/> Judgment         |
| <input type="checkbox"/> Communication   | <input type="checkbox"/> Gait or Balance   | <input type="checkbox"/> Consistency      |
| <input type="checkbox"/> Social Behavior | <input type="checkbox"/> Aggression        | <input type="checkbox"/> Performance      |
| <input type="checkbox"/> Anxiety         | <input type="checkbox"/> Short Term Memory | <input type="checkbox"/> Long Term Memory |

Other: \_\_\_\_\_

5. Would applicant be able to travel independently on fixed-route buses if they are medication compliant?  Yes  No

6. PCPT will not provide a Personal Care Attendant (PCA), nor will PCPT drivers help clients with their Activities of Daily Living. Does the applicant need a PCA to safely ride a PCPT Paratransit vehicle?  Yes  No If Yes, explain why:  
\_\_\_\_\_

7. PCPT Paratransit drivers do not enter buildings or contact on-sight staff members on behalf of a client. Can the applicant safely be left unattended at pickup or drop-off locations?  Yes  No If No, explain why: \_\_\_\_\_  
\_\_\_\_\_

*I certify the information provided above is correct.*

\_\_\_\_\_  
Signature of Licensed Healthcare Provider

\_\_\_\_\_  
Date

Please print your contact information: Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Business Address: \_\_\_\_\_

Florida Board Certificate or License Number: \_\_\_\_\_

# PCPT ADA Paratransit Application

## Form E Application for Other Paratransit Services

PCPT offers other Paratransit services based on an applicant's age, income, and access to transportation. Applicants may receive reduced fare or free rides, depending on qualifications and rides available at the time. When a client qualifies for other Paratransit services, PCPT informs the client of their fare when the reservation is made. To ensure the applicant receives the services they qualify for, please complete all this form.

Applicants Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Annual Household Income: \_\_\_\_\_ Income Sources: \_\_\_\_\_

Including Applicant, total number of people in household (complete details below): \_\_\_\_\_

<u>Name</u>	<u>Relationship to Applicant</u>	<u>Age</u>	<u>Licensed to Drive</u>	<u>Vehicle Type Owned</u>
_____			___ Yes ___ No	_____
_____			___ Yes ___ No	_____
_____			___ Yes ___ No	_____
_____			___ Yes ___ No	_____
_____			___ Yes ___ No	_____

Does Applicant own a vehicle? \_\_\_ Yes \_\_\_ No If Yes, what type? \_\_\_\_\_

Does any member of the household own a vehicle? \_\_\_ Yes \_\_\_ No Who? \_\_\_\_\_

How does the Applicant currently get to appointments and shopping? \_\_\_\_\_

List any other programs Applicant is enrolled in that provides transportation: \_\_\_\_\_

Can Applicant easily transfer from a wheelchair to a car? \_\_\_ Yes \_\_\_ No \_\_\_ N/A

If Applicant uses a wheelchair, what are the dimensions? \_\_\_\_\_

What is the combined weight of the wheelchair and Applicant? \_\_\_\_\_

Is wheelchair equipped with a seatbelt? \_\_\_ Yes \_\_\_ No \_\_\_ N/A

Can Applicant climb 3 12-inch steps into bus with handrails? \_\_\_ Yes \_\_\_ No \_\_\_ Sometimes

If checked *No* or *Sometimes*, please explain: \_\_\_\_\_

Applicant Signature: \_\_\_\_\_

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