Paratransit Eligibility Application

www.palmtran.org

Completed applications accepted via mail / fax / email or in person at:
Palm Tran CONNECTION
Community Transportation Coordinator
50 South Military Trail, Suite 101
West Palm Beach, Florida 33415
Monday – Friday
8am – 4:30pm
561-649-9838 option 4
1-877-870-9849 toll-free outside local calling area
Eligibility Fax: 561-656-7156
Email: connpalmeligibility@pbcgov.org

INSTRUCTIONS FOR COMPLETING THIS APPLICATION: Please complete the appropriate Part(s) of this application depending upon which programs you are eligible for. If you do not complete the appropriate Part(s), we will not consider your eligibility for that program. If you complete two or more Part(s), we will consider your eligibility for multiple programs. **Regardless of program preference, Part 1 must be completed in its entirety.**

Part 1: General Rider Information
Part 2: Applicant Signature Page
Part 3: Verification of Income ***Transportation Disadvantaged Program OR Bus Pass Program***
Part 4: Verification of Disability ***Americans with Disabilities Program***

Per the Americans with Disabilities Act (ADA), complementary Paratransit is not intended to be a comprehensive system of transportation for individuals with disabilities.

The completed application will be reviewed within 21 business days after it is received by Palm Tran CONNECTION to determine the applicant's eligibility for service. If a decision is not made within 21 business days of receiving a completed application, the applicant shall be treated as eligible and shall be provided service unless PTC denies the application. Applicants who are denied eligibility have the right to appeal that decision. Please contact the eligibility department if you have further questions.

The information in this application will be used by Palm Tran CONNECTION for the provision of transportation services. Information will be available to other transit providers as necessary for appropriate transportation services only. The information will not be provided to any other person or agency. This document is available in an alternative format upon request.

APPLICATIONS ARE PROCESSED IN THE ORDER THEY ARE RECEIVED.
PROCESSING MAY TAKE FROM 7 TO 21 BUSINESS DAYS OF RECEIPT TO COMPLETE.

Revised January 2014

Part 1
General Rider Information

Please Print

Last Name: _____ First Name: _____ MI: _____

Street Address: _____ Apt#:_____ Bldg#:_____

Building/Complex or Development Name: _____(or closest cross street/major intersection)

City: _____State: _____Zip:_____

Telephone: _____Date of Birth: _____

Email address:_____

In case of emergency, please notify:

Contact Name/Relationship/Address	Contact Phone Number

A. Please indicate below if you use any of the following mobility aids or equipment (check all that apply)

- ○Cane
- ○Crutches
- ○Leg Braces
- ○Oxygen
- ○Service Animal
- ○Sighted (person) Guide
- ○Rider cannot be left unattended
- ○Walker
- ○Manual Wheelchair
- ○Powered Wheelchair
- ○Powered Scooter/Cart
- ○White Cane (blind)
- ○Portable Medical Equipment (oxygen tank, etc.)
- ○Other (please specify)_____
- ○I don't use any of the above mobility aids or equipment

Note: We may not be able to accommodate you if your wheelchair/scooter is longer than 54 inches or wider than 34 inches or if your total weight when occupying your wheelchair exceeds 600 pounds.

B. Do you require the assistance of a Personal Care Attendant (PCA) (someone who must travel with you to assist you with daily life functions)? *Please note that we may require you to travel with a PCA if your condition or disability is severe.*

○ **No** ○**Always** ○**Sometimes**

C. Do you need to have information given to you in an alternative format? If yes, please indicate: ○Large print ○Audio CD/Tape ○Braille ○Other:_____

Part 2
Applicant Certification - Signature

I understand that the information about my disability contained in this application will be kept confidential and shared only with professionals involved in evaluating my eligibility for the provision of transportation services. Your information will also be available to other transit providers as necessary for appropriate transportation services. The information will not be provided to any other person or agency. I certify that, to the best of my knowledge, the information in this evaluation form is true and correct. Any person who knowingly makes a false or misleading statement in an application may be denied eligibility for Paratransit services.

Applicant's Signature: _____ **Date:** _____

If someone assisted you in completing this form, please provide contact information:
Name: _____ Phone: _____

In Case of an Evacuation:
In the event of a mandatory evacuation order issued by Palm Beach County Emergency Management due to a Hurricane or Flood, would you need transportation to a shelter?

○**Yes** ○**No**

To register for the Special Care Unit, please contact the Palm Beach County Emergency Operations Center at (561) 712-6400.

Part 3
Application Certification – Verification of Income

A. To apply for the Transportation Disadvantaged (TD) Program, please complete the following:

Total monthly income $_____

Please **attach proof** of your total income, before tax, including wages, tips, any Social Security income, Pension and other.

Acceptable forms of proof include:

1st page of your Tax return	DCF Benefit Letter
Minimum of (2) pay stub statements	Retirement/Pension Statement
Social Security Income verification	Unemployment Compensation Income verification

Do you have a physical or mental impairment that substantially limits one or more of the major life activities?* ○No ○Always ○Sometimes

If yes, Please specify the nature of the impairment:

○Mobility Impairment (Stroke, brain spinal nerve trauma)

○Neurological Disability (MS, MD, Cerebral Palsy, Epilepsy, Alzheimer's, Parkinson's, other)

○Visual Disability (Macular Degeneration, visually impaired, legally blind)

○Uncontrolled Fatigue (Chemo/Radiation, Dialysis)

○Cognitive or Sensory Impairment (Autism, down syndrome, dementia, developmental, other)

○Impairment Related (Hearing impaired, Cardiac/COPD, respiratory, arthritis, neuropathy)

Question is required, but not used in determining your eligibility

Part 4
Applicant Certification – Verification of Disability

A. To apply for the American's With Disability Act Program, please complete the following:

Please indicate below the reasons why you are seeking Door to Door eligibility (check all that apply)

To qualify for Palm Tran CONNECTION a person must be **UNABLE** to use Palm Tran fixed-route buses due to a physical or mental impairment related condition

○Because of my disability, I can **never** use the Palm Tran fixed-route bus service

○I can use Palm Tran fixed-route buses sometimes, but only if they are equipped with wheelchair lifts

○I can use Palm Tran fixed-routes buses to go some places, but in other places I cannot get to or from the bus stops

B. What type(s) of disabilities prevent you from using Palm Tran buses? (check all that apply):

○Mobility Impairment (Stroke, brain spinal nerve trauma)

○Neurological Disability (MS, MD, Cerebral Palsy, Epilepsy, Alzheimer's, Parkinson's, other)

○Visual Disability (Macular Degeneration, visually impaired, legally blind)

○Uncontrolled Fatigue (Chemo/Radiation, Dialysis)

○Cognitive or Sensory Impairment (Autism, down syndrome, dementia, developmental, other)

○Impairment Related (Hearing impaired, Cardiac/COPD, respiratory, arthritis, neuropathy)

Please describe your disability in more detail: _____

_____

C. Is the disability described above temporary or permanent?

○Temporary, I expect it to last for another _____months

○Permanent

○I don't know

D. Have you ever used Palm Tran fixed-route bus service?

○Yes, I use the following bus routes _____

○No

Part 4 (continued)
Applicant Certification – Verification of Disability

E. When are you UNABLE to use the Palm Tran fixed-route bus? (Please indicate below – check all that apply to you)

○I can use Palm Tran regular bus service for some trips, but other times there are barriers that prevent me from using the bus.

○I have difficulty understanding, become disoriented easily and/or remembering all of the things I would have to do to use the bus.

○I can only get to and from bus stops if the distance is not too great and there are curb cuts and sidewalks on the route.

○I can only wait at Palm Tran bus stops if there is a bench or shelter and/or I cannot cross busy streets and intersections.

○The severity of my disability can change from day to day. I can ride the bus only when I am feeling good.

○I have difficulty or cannot climb stairs and can only board a Palm Tran bus if is has a lift or ramp.

○I have a health condition and cannot ride the bus if the walk is too far or if the weather is too hot.

F. Would any of the following help you to use the fixed-route buses?

○Route and schedule information
○Bus stops closer to your home
○A communication aid
○Bus stops closer to where I live and where I need to go
○None of these would help
○Travel Training (how to ride the bus)

G. Can you ask for and follow written or verbal instructions to use Palm Tran fixed-route buses?

○Yes ○No ○Sometimes

If you choose either NO or Sometimes, please check all that apply

○I get confused and might get lost ○I probably could with instruction

○Other people cannot understand me ○Other:_____

Part 4 (continued)
Applicant Certification – Verification of Disability

H. Without the help of someone else, are you ABLE to do the following? (check all that apply)

- ○ Walk up and down three steps if there are handrails on both sides
- ○ Use a telephone to get information
- ○ Ask for and follow written or oral instructions
- ○ Cross the street if there are curb cuts
- ○ Get on and off a Palm Tran bus if it has a wheelchair lift
- ○ Wait 30 minutes at a bus stop that does not have a bench or shelter
- ○ Easily hear the bus drivers' voices when they announce bus routes while you are standing outside or inside the bus
- ○ Step on and off a sidewalk that does not have a curb cut
- ○ Cross streets and intersections
- ○ Hear traffic well enough to safely cross streets
- ○ See well enough to walk to a bus stop if someone shows you the way once

I. Using a mobility aid (wheelchair, etc.) or on your own, how far can you walk or travel?

- ○ Cannot walk outside my house/apartment
- ○ I can get to the curb in front of my house/apartment
- ○ I can walk or use wheelchair up to 3 blocks
- ○ I can walk or use wheelchair up to 6 blocks
- ○ I can walk or use wheelchair up to 9 blocks

J. Can you WAIT up to 30 minutes for the Palm Tran fixed-route bus at a bus stop?

- ○ Yes
- ○ Yes, only if the stop has a bench and shelter
- ○ Yes, but I do not like to wait that long
- ○ No, explain:_____

If applying for the Americans with Disabilities Program or the Transportation Disadvantaged Program, please have your PHYSICIAN complete the attached (MEDICAL VERFICATION FORM)

MEDICAL VERIFICATION

(THIS PORTION TO BE COMPLETED BY APPLICANT)

Please Print/Type Below

I certify that I am a person with a disability as described by the American with Disabilities Act. I further state that my physician or other certifying practitioner has completed the statement of certification below on my behalf, as required.

Name of Applicant as printed on the Identification

Signature of Applicant, Parent or Guardian of Applicant

Date of Birth Sex

Date Signed

Street Address City State Zip Code

MEDICAL VERIFICATION, CONTINUED

(THIS PORTION TO BE COMPLETED BY A LICENSED PHYSICIAN)

1. Keeping in mind that all Palm Tran buses are 100% wheelchair accessible, can the applicant ever use a regular bus?

☐ **Yes** ☐ **No** ☐ **Sometimes**

2. **MOBILITY IMPAIRMENT:**

☐ Non-ambulatory disability (required wheelchair to travel) Please specify the condition which requires full time use of a wheelchair. _____

☐ Ambulatory disability (ambulation may be limited, but able to walk with or without mobility aid, may use wheelchair but can transfer to a seat with little or no assistance).

☐ Amputation (detail extremity): _____

☐ Stroke

☐ Brain Spinal Nerve Trauma

☐ Other: _____

3. **MOBILITY AID: PLEASE INDICATE ALL THAT APPLY**

☐ Standard Wheelchair ☐ Cane ☐ Other: _____

☐ Wide Wheelchair ☐ Walker

☐ Scooter ☐ Crutches _____

☐ Wide Scooter ☐ Braces

☐ Service Animal

4. **NEUROLOGICAL DISABILITY (MOTOR DYSFUNCTION):**

☐ Multiple Sclerosis ☐ Epilepsy ☐ Other: _____

☐ Muscular Dystrophy ☐ Alzheimer's

☐ Cerebral Palsy ☐ Parkinson's _____

5. **VISUAL DISABILITY:**

☐ Macular Degeneration

☐ Visually Impaired

☐ Legally Blind – If this person is legally blind complete the following:

Corrected visual acuity: Right Eye _____ Left Eye _____ *(Please attach Snellen reports of both eyes)*

Corrected Field of vision: Right Eye _____ Left Eye _____ *(Please attach Perimeter chart reports of both eyes)*

6. **UNCONTROLLED FATIGUE:**

☐ Chemo/Radiation ☐ Dialysis

MEDICAL VERIFICATION, CONTINUED

(TO BE COMPLETED BY A LICENSED PHYSICIAN)

7. COGNITIVE OR SENSORY IMPAIRMENT:

☐ Autism ☐ Dementia ☐ Other:_____
☐ Down Syndrome ☐ Alzheimer's
☐ Developmental Disability ☐ Emotional _____

Level of impairment: ☐ Mild ☐ Moderate ☐ Severe ☐ Profound I.Q.: _____ (*Must specify*)

8. IMPAIRMENT RELATED CONDITION:

☐ Hearing Impaired ☐ Arthritis ☐ Other:_____
☐ Cardiac/COPD ☐ Neuropathy
☐ Respiratory _____

9. DESCRIBE IN DETAIL THE APPLICANT'S PRIMARY DISABILITY: (BE SPECIFIC):

_____

_____

10. IS THIS DISABILITY:

☐ Permanent
☐ Temporary: This is to certify that the applicant stated within is a person with a temporary disability (six months or less) that limits or impairs his/her ability to walk or is temporarily sight impaired.
Date of Disability: _____ ***through recovery date of*** _____

Is this disability controlled by medication? ☐ Yes ☐ No
Explain:_____

_____

11. PERSONAL CARE ATTENDANT

☐ Applicant requires a personal care attendant

Please attach any pertinent medical documentation (Test Results, Notes, Reports, etc.) that would help to explain the diagnosis or limitations on the applicant's ability to utilize Palm Tran's mass transit system.

WARNING: ***Any person who knowingly makes a false or misleading statement in an application or certification may be denied eligibility to Paratransit services.***

_____ _____ _____
Print/Type Name of Certifying Authority Signature Date Signed

_____
Business Street Address (Area Code) Telephone Number Fax Number

_____
City State Zip Code

Certification or License No. (**REQUIRED**)_____ of a Physician, Osteopathic or Podiatric Physician, Chiropractor, Optometrist, Advanced Registered Nurse Practitioner under the protocol of a licensed physician or a Physician Assistant licensed under Chapter 458 or 459.

LICENSED IN THE STATE OF:_____

50 South Military Trail, Suite 101
West Palm Beach, Florida 33415

Palm Beach County
Board of County Commissioners

County Administrator
Verdenia C. Baker