

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? _____

Yes / No

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 Stretcher 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.

- Do you have children 4 years old or younger that require transportation? Yes No
If yes, do you need a Car Seat? Yes No

- 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.

- 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**:

- 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.

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.

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.

Applicant's 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 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: _____