



BOARD OF COUNTY COMMISSIONERS BROWARD COUNTY, FLORIDA

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 your signature and return it to us by mail. Your **Florida licensed** healthcare provider most familiar with your disabling condition(s) is to complete and sign the Medical Verification form(s).

Riders who are 14 years of age and older may travel unaccompanied. Approved riders **13 years of age or younger** must travel with a Personal Care Attendant (PCA). A PCA is someone you hire or designate to help you and/or your child meet your daily living needs. Broward County Transit (BCT) does not provide PCA's and is authorized when medically justifiable. If you use one please indicate so on your application.

As an applicant, you are required to have an in-person functional assessment at our contracted facility. You will receive a letter with instructions on how to complete this next step. If you need transportation to and from the facility please follow the directions on your letter. Upon receipt of your results we will review your file to determine your eligibility and contact you by mail.

If you need additional information please contact customer service: 954.357.8400 (Voice), 954.357.8302 (TTY), or visit us on the web at: broward.org/BCT.

When completed please mail the entire application to:

Broward County Transit - Paratransit Services
1 North University Drive, Suite 3100 A
Plantation, FL 33324

LEFT BLANK INTENTIONALLY

**PLEASE PRINT
LEGIBLY**

DO NOT WRITE IN THIS SPACE

Received Date: _____ Process Date: _____
Closest Bus Stop (Feet): _____ ADA Category: 1 2 3
Equip/Disability: _____ PCA H2H
Reviewed By: _____
Assesment Date: _____ Approval Date: _____
ADA Conditions: _____ Exp Date: _____

Client ID #: _____

New Applicant Yes: _____

Part 1 - General Information

Last Name: _____ First Name: _____ MI: _____

Street Address: _____ Apt: _____ Bldg.: _____

Bldg./Subdivision Name: _____ E-mail: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Other Phone: _____

Date of Birth: _____

If someone assisted you to complete this form, please identify below:

Name: _____ Phone: _____

Check the box to have information & material sent other than standard?

Large Print Other: _____

In case of emergency, who do we contact? (Required)

Name: _____ Phone: _____

Relationship: _____

Other Phone or E-mail: _____

Additional Contact: _____

Veterans VA trip discount:

Are you a United States veteran? YES NO

To receive the reduced discounted fare for trips to the Veteran Affairs (VA) clinic,
please provide proof of Honorable Discharge status.

Part 2 – Information About Applicant’s Disability

1. Please check the box of all conditions that stop you from riding the BCT fixed route service independently. Then submit the Medical Form A, to your medical provider to complete and sign unless directed otherwise in parenthesis.

- | | | |
|--|--|---|
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Quadriplegia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke/Cerebral Trauma
(Occurrence Date)_____ |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Intellectual Disability (D)
(IQ#)_____ | <input type="checkbox"/> Surgery (Date)_____ |
| <input type="checkbox"/> Chronic Obstructive/
Pulmonary Disease | <input type="checkbox"/> Kidney Disease/Dialysis | Type_____ |
| <input type="checkbox"/> Cognitive (D) | <input type="checkbox"/> Lupus | <input type="checkbox"/> Thrombosis |
| <input type="checkbox"/> Congestive Heart
Failure | <input type="checkbox"/> Mental Illness (D) | <input type="checkbox"/> Visual Impairment (B) |
| <input type="checkbox"/> Epilepsy/Seizure
Disorder (C) | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Other:_____ |
| | <input type="checkbox"/> Paraplegia | <input type="checkbox"/> Other:_____ |
| | <input type="checkbox"/> Parkinson’s Disease | |

2. Do you use any of the following mobility aids or equipment? (*Required*)

- | | | |
|---|-----------------------------------|---|
| <input type="checkbox"/> Oxygen | <input type="checkbox"/> Cane | <input type="checkbox"/> Powered scooter |
| <input type="checkbox"/> Leg braces | <input type="checkbox"/> Walker | <input type="checkbox"/> Powered wheelchair |
| <input type="checkbox"/> Long white cane | <input type="checkbox"/> Crutches | <input type="checkbox"/> Manual wheelchair |
| <input type="checkbox"/> Service animal - Describe: _____ | | |
| <input type="checkbox"/> Other: _____ | | |

3. Do you require the assistance of a Personal Care Attendant* (PCA)?

** Personal Care Attendant (PCA) is someone who is designated or employed by you specifically to help you, the eligible client, meet your personal needs, including traveling. A PCA may always travel with an eligible client. A PCA is not provided by BCT and is authorized only when a medically justifiable need is established.*

Yes, I need assistance with: (*check all that apply*)

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

No, I do not need assistance when traveling.

Part 3 – Questions About Using BCT Fixed-Route Buses

4. Have you ever used BCT fixed route buses?

- Yes, I typically use the fixed-route buses _____ times a week.
- Yes, I did but stopped on _____ because _____
- No

5. What might help you ride BCT fixed route buses? *(check all that apply)*

- A communication aid
- Route and schedule information
- If someone would teach me how to travel on the buses
- If the bus stops were closer to where I live and where I need to go
- Other, describe: _____
- None of these would help

6. Can you ask for and follow written / oral instructions to use BCT buses?

- Yes No SOMETIMES

If you choose No or Sometimes, *(check all that apply)*

- I probably could with instruction
- I get confused and might get lost
- Other people cannot understand me
- Other: _____

7. Are you able to get to and from bus stops on your own?

- Yes No Sometimes

If you choose No or Sometimes, *(check all that apply)*

- I probably could if someone shows me how
- I get confused and cannot find my way
- I cannot travel outside when it is too hot
- I cannot if the street or sidewalk is too steep
- I cannot cross busy streets and intersections
- I cannot get to places if there are no curbs-cuts
- I cannot see well at night
- Other: _____

8. How far can you travel on your own or using your mobility aid?

- I cannot get outside my residence
- I can get to the curb in front of my residence
- I can get up to ____ blocks

9. Can you wait outside up to 30 minutes for a fixed route bus?

- Yes
- Yes, but only if the stop has a bench and shelter
- No, explain: _____

10. Are you able to use a bus ramp or lift?

Yes No Sometimes I do not know

If you choose No or Sometimes, *(check all that apply)*

I am not familiar with bus ramps or lifts

I probably could if someone shows me how

I do not want to use the lift

Other: _____

11. If you are able to get on and off a fixed route bus, can you get to a seat or wheelchair position by yourself and ride the bus?

Yes No Sometimes I do not know

If you choose No or Sometimes, *(check all that apply)*

I have a balance problem

I need a seat nearest the door

I have trouble finding a seat

Other: _____

12. If you are able to get on and off a fixed route bus, do you know where to get off or can you find out by yourself?

Yes No Sometimes I do not know

If you choose No or Sometimes, *(check all that apply)*

I get confused and cannot remember where I am going

I can if the driver calls out the stops

I probably could with travel training

13. Check the box(es) that reflect(s) the reason why you can't ride the bus.

Busy street to cross Inclines Time of day

Lack of curb cuts No crosswalk light

Construction Distance

No sidewalk/Sidewalk condition (Describe): _____

14. Is your condition affected by temperature or weather? Yes No

If yes, please write the upper and lower temperature where your condition is affected: _____

15. Provide names and address of places you currently go or plan to go:

Signature Page

Please Sign and Date Part 4 and Part 5

Part 4 - Applicant Certification

By signing below you agree the information you provided is correct to the best of your knowledge. *(If you are unable to sign, your power of attorney may sign for you; attach proof of POA).*

I understand the purpose of this application is to determine if there are times when I cannot use the BCT fixed route service and must use ADA Paratransit services. I certify, to the best of my knowledge, that the information in this application is true and correct. I understand 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's Signature

Date

Part 5 - Applicant Medical Information Release

By signing below I give permission for my Health Care Provider(s) to release information for the purpose of facilitating my eligibility determination or providing me with transportation. *(If you are unable to sign, your power of attorney may sign for you; attach proof of POA).*

Applicant's Signature

Date

**ATTACH A COPY OF YOUR VALID FLORIDA DRIVER'S
LICENSE/ID OR CURRENT GOVERNMENT ISSUED ID
WITH THIS APPLICATION.**

TOPS! Paratransit Eligibility Medical Verification Forms

Please ask your Florida Licensed/Certified Health Care Provider to complete the medical form that best describes your need for Paratransit services.

***Note to Medical Provider:** By completing and signing the medical documents, you certify to the truth and accuracy of the information provided on the application, to the best of your professional knowledge. The Americans with Disabilities Act of 1990 requires BCT to provide services to persons who are unable to use the fixed-route bus system due to a disability. The information you provide will allow BCT to make an appropriate evaluation of your clients' eligibility.*

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

Category 1: Individuals who, as a result of a physical or mental impairment (including visual impairments) and without the assistance of another individual (except the operator) cannot board, ride or disembark from an accessible transit vehicle.

Category 2: Individuals who can independently use accessible vehicles, but none are available on their route.

Category 3: Individuals who have a specific impairment-related condition that prevents them from independently getting to/from a stop.

Located at broward.org/bct, you may submit additional completed verification forms as applicable:

Form B - Vision

Form C - Epilepsy or Seizure Disorders

Form D - Cognitive or Mental Health Conditions

**TOPS! Paratransit Eligibility
Form A: General Medical**

To be completed by a Licensed Health Care Provider

Applicant's Name: _____ Date of Birth: _____

1. Please write how the applicant's disability stops them from using the BCT bus independently? *(Note: BCT buses are 100% handicapped accessible).*

2. Date of onset? _____

3. Is applicant's functional limitation permanent? Yes No
If no, expected duration? # of Months _____ # of Years _____

4. For safety reasons, does the applicant need to travel on TOPS! at all times, with a PCA? Yes No If yes, please explain:

5. For safety reasons, can applicant be left unattended at pickup or drop-off locations? Yes No If no, please explain:

I certify the information provided above is correct.

Signature of Licensed Health Care Provider

Date

Clearly print your contact information below:

Name: _____ Board cert. # or Lic. #: _____

Phone #: _____ Fax #: _____

Business address: _____