

## ELIGIBILITY APPLICATION FOR SHARED RIDE PARATRANSIT (DOOR-TO-DOOR) SERVICE

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**Applicant Name** (please print legibly)

**Date:**

If you are seeking Medicaid Transportation, please call (866)  
762-2237 Florida Relay Voice: (800) 955-5700; TTY: (800) 955-8771

- **What type of para-transit services are you applying for**      **ADA and/or**      **TD?**  
(See eligibility requirements)
  
- **Are you requesting transportation services for Dialysis or Chemotherapy?**      **Yes**      **No**
  
- **TD Bus Pass Program**      (See eligibility requirements)

**For questions or to submit this application contact our office at the following information:**

**Office Hours: Monday through Friday from 8 AM to 5 PM**

**Address: Lake County Transit Management**

**560 E. Burleigh Blvd., Tavares, FL 32778**

**Phone: (352) 742-2612 option 2    Fax: (352) 508-5488**

**Email: [lctm@ratpdev.com](mailto:lctm@ratpdev.com)**

### **INFORMATION ABOUT LAKE COUNTY CONNECTION SERVICES**

Lake County Connection can be used for medical appointments, nutritional (includes grocery shopping), employment, educational and life sustaining (Social/Recreational) trips. The information requested on this application is intended to help us determine the funding program you may qualify for.

To assist in determining your level of eligibility, applicants may be required to attend an in-person interview. All information provided may be verified and confirmed. Please attach any supporting documentation requested in the following sections.

All users of Lake County Connection are required to complete an application regardless of whether the applicant is new, recertifying, resides in a nursing home, or a dialysis patient.

## ELIGIBILITY CRITERIA

### ADA QUALIFICATIONS AND GUIDELINES:

- This program typically services the urban areas of Lake County and operates in conjunction with LakeXpress (LX) fixed route bus service.
- This program is for any trips that origin and destination locations both reside within three-quarters (3/4) of a mile radius of an LX fixed route. This area is known as the ADA Corridor.
- This program operates on the same days and times as the LX services. Since this program operates in conjunction with the LX fixed route program, this program is only usable if an individual could feasibly make a similar trip utilizing the LX program directly.
- This program is intended for individuals that have a disability or condition that prevents the applicant from independently using the LX fixed route program service all the time, temporarily, or only under certain circumstances. All disabilities and/or conditions must be verified by an acceptable medical professional and documented on the Medical Verification Form (MVF) of this application.
- Having a disability and/or condition alone does not guarantee eligibility under the ADA program. Eligibility is based on the individual's functional ability to use the LX fixed route program and is not a medical or psychiatric decision.
- The ADA certification process may involve a telephone interview and/or a personal functional assessment to determine if and how the applicant's transit needs can be met.
- All ADA program trips have a fare of \$2.00 each way and is ineligible for any fare reduction programs.

### TRANSPORTATION DISADVANTAGED (TD) QUALIFICATIONS AND GUIDELINES:

- This program typically services the rural areas of Lake County and allows for transportation in areas that the LakeXpress (LX) fixed route bus service does not reach. Therefore, this program allows for transportation services that are not covered under the ADA program.
- To determine if an applicant meets the program eligibility criteria for the TD program, the applicant must first have no other means of transportation available to them (including LakeXpress fixed route bus service) and meet at least one of the following criteria:
  - Applicant's age is 60+; **or**
  - Have a recognized disability; **or**
  - Applicant's annual gross **household** income is at or below **200%** of the Department of Health and Human Services poverty guidelines (<https://aspe.hhs.gov/poverty-guidelines>)
- Please note that an applicant must provide information towards all the criteria fields to make an accurate determination.
- No other means of transportation available to an individual also includes access to any relative in a household that can operate a vehicle in their behalf and/or owning a vehicle with no

obvious operating restrictions. Please note that falsifying ownership of or accessibility to a vehicle is grounds to revoke a current TD applicant's eligibility and may even bar an individual from future service opportunities.

- Proof of **Household Income** is required for all individuals that earn an income within the household unless there is a legitimate reason that creates a separation of the incomes within the households such as renter/tenant relationship.
- This program is funded from the state and depending on the availability of funds, trips may be denied based on the purpose of the trip. Trip priorities are ranked in order of highest priority as follows: (1) Critical Medical, (2) Other Medical, (3) Nutritional, (4) Employment, (5) Educational, and (6) Life-Sustaining/Other (Recreational) Trips.
- TD program operates Monday through Friday for all trip purposes as allowed by available funds. Saturday services are provided for critical medical trips (dialysis) only. The program does not provide any services on Sunday.
- TD program does provide Out of County Trips to Gainesville on Monday, Wednesday, and Fridays only. Trips to Orlando are provided on Tuesday and Thursday only.
- All TD program trips within the Lake County boundary have a fare of \$2.00 each way. For trips to Gainesville, the fare is \$10.00 each way. For trips to Orlando, the fare is \$5.00 each way. Applicants may request a Hardship application that if eligible would modify the required fare for certain TD program trips.

### **TD BUS PASS PROGRAM**

- A fixed-route bus pass is provided at no cost to qualifying individuals who are financially prohibited from using the fixed-route system. Eligible recipients receive bus passes via U.S. Mail only. TD bus passes cannot be picked up at County facilities.
- To qualify for the TD Bus Pass Program, you must live in Lake County, have no means of transportation, including family and friends, and an income at or below 200% of the federal poverty level.

### **How do I get a TD Bus Pass?**

- Complete and mail the application, along with the required Proof of Income to the address shown on the application.
- To check the status of your application call 352-742-1940 three weeks (21 days) after the submission of your paperwork.
- Eligible TD customers may receive a 30-day bus pass, a 10 non-consecutive day bus pass, or an all-day bus pass at no cost to the passenger.

**INSTRUCTIONS FOR COMPLETING THIS APPLICATION**

1. When completing the application, please type or print legibly and sign where indicated.
2. Unreadable, incomplete, or unsigned applications will not be accepted and will be returned. If submitting via email, the only acceptable format of the application is PDF from an actual document scanner. Camera scanners are not accepted.
3. Processing of this application can take up to **21** calendar days. The **21-day** period begins after a completed (includes all required supporting documents to be attached) application is received.
4. All applicants will be notified of the application outcome by letter or email.
5. Applications will remain active for approximately (two years).
6. Completing this application does not automatically indicate approval for either the ADA program, TD program or both.
7. To aid with the completion of this application, sections will be marked with logos. Some sections are required by both programs, but if an applicant wishes to only apply for just the ADA program or just the TD program, then please complete sections with the following logos:

ADA Program -



TD Program -



**Lake County Connection will use the information in this application for the provision of transportation services only. The information will not be provided to any other person or agency outside of the Lake County Transit system.**



**Section 1 – ADA & TD Program**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ Bldg. #: \_\_\_\_\_

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

Name of Subdivision, Complex, Facility, or Nearest Intersection/Bus Route:

If the Subdivision, Complex, or Facility is a gated community, please provide the gate code: \_\_\_\_\_

Mailing Address (if different from above):

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Male      Date of Birth: \_\_\_\_\_      SSN: \_\_\_\_\_

Female      Home Phone: \_\_\_\_\_      Cell Phone: \_\_\_\_\_

E-mail (optional): \_\_\_\_\_

Are you a Medicaid Recipient?    Yes    No      Medicaid #: \_\_\_\_\_

Do you require materials or correspondence in an alternative format?    Yes    No

➤ If yes, please specify:    Large Print    Audio File by (    CD or    Flash Drive)

**Emergency Contact**

Name	Relationship	Primary Contact Number	Secondary Contact Number

**Alternate Emergency Contact**

Name	Relationship	Primary Contact Number	Secondary Contact Number

Do you authorize any other person(s) to make travel arrangements in your behalf? If so, please complete the following table with the information requested:

Name	Phone Number

If you reside in a facility (nursing home, assisted living facility, etc.), does the facility have a vehicle to transport residents?       Yes    No

Have you ever been transported by the facility?       Yes    No

List any impairments, disabilities, or other conditions you may have that prevents you from using the LakeXpress fixed route bus service program:

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How long have you had this condition? \_\_\_\_\_ Is your condition permanent? \_\_\_\_\_

**Please indicate below if you use any of the following mobility aides or equipment:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Wheelchair                       | <input type="checkbox"/> Powered Scooter                        | <input type="checkbox"/> Powered Wheelchair |
| <input type="checkbox"/> Walker                           | <input type="checkbox"/> Long White Cane                        | <input type="checkbox"/> Portable Oxygen    |
| <input type="checkbox"/> Cane                             | <input type="checkbox"/> Leg Braces                             | <input type="checkbox"/> Crutches           |
| <input type="checkbox"/> Assisted Walking                 | <input type="checkbox"/> Needs Personal Care Attendant / Escort |   |
| <input type="checkbox"/> Service Animal (describe): _____ | <input type="checkbox"/> Other: _____                           |   |



**Section 2 – ADA Program**

**ADA Functional Ability**

Without the assistance of someone else, can you:

Board a Bus?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Read/Understand directions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Handle coins and bus transfers?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Travel on a sidewalk?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Travel to the nearest bus stop?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stand at a bus stop?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Identify the correct bus?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Walk ¾ mile?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Climb a 12-inch step?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cross a street?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Balance yourself while seated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Grip handles and railings?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Give your address and phone number?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recognize landmarks?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wait outside for more than 15 minutes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Travel through crowds?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you able to travel alone?  Yes  No

If you use a mobility aid, is the doorway / entrance of your residence accessible?<sup>1</sup>  Yes  No

Have you used or are you currently using the LakeXpress fixed route service?<sup>2</sup>  Yes  No

<sup>1</sup> Note: LCC Drivers cannot assist mobility devices into or out of a residence, up or down stairs, or through grass or sand.

<sup>2</sup> Note: All LCC and LakeXpress buses are fully accessible with wheelchair lifts/ramps and many of the LakeXpress buses can kneel for easy access.

How far can you walk? \_\_\_\_\_ How far can you walk with a mobility aid? \_\_\_\_\_

Do you need the wheelchair lift to board the bus?  Yes  No

Do you have any limbs that are in a cast, brace, fused or otherwise unbendable?  Yes  No

**If you do not use the LakeXpress service, please read the following statements and check all those which apply to you. You may select more than one:**

- I have a temporary disability which prevents me from getting to the bus stop or using the service. I will need ADA service only until I recover.
- I cannot get to the bus stop.
- I have a cognitive disability which prevents me from remembering and understanding all I must do to find my way to and from the bus stop, and to ride the bus.
- I have a visual disability which prevents me from finding my way to and from the bus stop.
- I have a severe medical condition. My condition results in an impairment which makes it impossible for me to use regular bus service.
- I have an episodic disability. I can use the LakeXpress fixed route services on days when I am feeling well, but on bad days, I can't make it to the bus stop, or even get on the bus.

**NOTE: Lake County Office of Transit Services offer Travel Training for LakeXpress (LX) fixed route services to teach individuals how to use the LX services. Participation in the Travel Training Program will not affect your eligibility for ADA Paratransit service.**

- Check here if you are interested in receiving additional information on Travel Training.

**ADA Paratransit Program requires that a Medical Verification Form (MVF) be completed by an accepted licensed medical professional. The Medical Verification Form (MVF) is the last two (2) pages of this application.**



### Section 3 – TD Program

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Is the LakeXpress fixed route service accessible from your home?  Yes  No

Are there any circumstances preventing you from using the LakeXpress bus service?  Yes  No

If yes, please describe: \_\_\_\_\_

Do you have weekly scheduled medical appointments?  Yes  No

How many medical appointments do you usually have in a month? \_\_\_\_\_

How do you currently travel to your destination(s)?

Bus       Taxi       Drive yourself       Other (please explain): \_\_\_\_\_

Do you currently own a motor vehicle?  Yes     No    If yes, what prevents you from driving the vehicle? \_\_\_\_\_

Do you have relatives or friends who can transport you?  Yes     No

What are the names and ages, including yourself, of the people living in your household?

\_\_\_\_\_

\_\_\_\_\_

Does anyone living in your household own a car?  Yes     No    *If Yes, please provide a letter explaining why any vehicle available in the household is not accessible to the applicant for transportation needs.*

Please indicate the reason you are seeking Transportation Disadvantage (TD) program services (check all that apply):

- I do not live within the LakeXpress fixed route service area.
- I am 60 years of age or older.
- My income level falls below current federal poverty guidelines (proof of income is required)
- Have a recognized disability.
- Other (please specify): \_\_\_\_\_

### **Verification of Income**

What is the **combined monthly household income of everyone living in the household**? \$ \_\_\_\_\_

Are you currently receiving public assistance such as food stamps?     Yes     No

➤ If yes, how much do you receive monthly? \$ \_\_\_\_\_

**Monthly Income Breakdown:** please include all wages, disability payments, Social Security payments, pensions, dividends, investments, etc. that makes up your **total gross annual household income**.



To process your application, **proof of income is required of everyone that make up the total household income.** This information must be submitted with the application.

Please indicate the total household income from each of the below categories:

Salary: \$ \_\_\_\_\_ SSI: \$ \_\_\_\_\_ SSDI: \$ \_\_\_\_\_ Pension: \$ \_\_\_\_\_  
 Interest / Dividends: \$ \_\_\_\_\_ Workman's Comp: \$ \_\_\_\_\_ Relatives: \$ \_\_\_\_\_  
 Other (explain): \_\_\_\_\_ \$ \_\_\_\_\_

**Acceptable forms of proof of the total household income include:**

- Two (2) of your most recent Paycheck Stubs (consecutive)
  - Bank Statements for all accounts that manage income for two (2) consecutive months
  - Social Security Income Verification Notice/Letter
  - First (1<sup>st</sup>) page of your Tax Return
  - Retirement / Pension Statement
  - Unemployment Compensation Income Verification Notice/Letter
  - Department of Children and Families Benefit Letter
- *If you are a roomer/boarder, you must provide a statement from your landlord listing the amount you pay for board, utilities, meals, and any other included expense.*
- *If you do not have any income, please provide a letter from the individual or facility that is supporting you.*

**Monthly Household Expenses:**

Housing: \$ \_\_\_\_\_ Utilities: \$ \_\_\_\_\_ Vehicle: \$ \_\_\_\_\_ Food: \$ \_\_\_\_\_  
 Cable: \$ \_\_\_\_\_ Phone: \$ \_\_\_\_\_ Cell Phone: \$ \_\_\_\_\_ Medical: \$ \_\_\_\_\_  
 Pharmacy: \$ \_\_\_\_\_ Fuel: \$ \_\_\_\_\_ Home Insurance: \$ \_\_\_\_\_  
 Car Insurance: \$ \_\_\_\_\_ Other: \_\_\_\_\_ Cost \$: \_\_\_\_\_

**Total Monthly Household Expenses: \$ \_\_\_\_\_**

Would you ride LakeXpress if you were provided with a free bus pass?  Yes  No



## Section 4 – ADA & TD Program

### Certification and Acknowledgement

I understand and affirm that the information provided in this application for either ADA Program and/or TD Program services is true and correct to the best of my knowledge and will be kept confidential and shared only with medical and transportation professionals involved in evaluating and determining my needs and eligibility for transportation to and from eligible services as well as appointments.

I understand that providing false or misleading information or making fraudulent claims or making false statements on behalf of others could constitute a felony under the laws of the State of Florida and could result in my eligibility status being revoked and

I agree to notify Lake County Connection if there is any change in personal circumstance, change in personal information such as address or phone number, or I no longer need to use any of the program services applied for. I understand that if I am approved for any program services, I must recertify two years from the date of approval for services.

Lake County Board of County Commissioners and our Operator, Lake County Transit Management, Inc. collects your social security number, if applicable, for the following purposes:

- *Identification and verification*
- *Billing and Payments*
- *Benefit Processing*

Social Security numbers may be used as a unique numeric identifier and may be used for search purposes.

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

Signing for Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_



## Medical Verification Form

If you are applying for ADA Paratransit door-to-door services due to a medically verified physical disability, cognitive condition, or impairment, this Medical Verification Form must be completed and signed by an accepted licensed medical professional.

### Accepted medical professionals include:

- Medical Doctor
- Doctor of Osteopathic Medicine
- Doctor of Chiropractic
- Occupational Therapist (Licensed/Registered)
- Audiologist
- Ophthalmologist
- Psychologist
- Licensed Nurse Practitioner
- Registered Nurse
- Physical Therapist
- ARNP

Be sure to print your name, date of birth, and the last 4 digits of your Social Security Number on the form to assist your medical professional.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Last 4 digits of Social Security Number: \_\_\_\_\_

### Applicant's Release

I understand that the purpose of this evaluation form is to determine my eligibility for ADA Paratransit door-to-door services. 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. I hereby authorize my medical representative to release all information regarding my medical condition to Lake County Connection D.B.A. Lake County Transit Management, Inc. I understand that providing false or misleading information could result in my eligibility status being revoked. I agree to notify Lake County Connection within ten (10) days if there is any change in circumstances or I no longer need to use Paratransit services.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**If applicant is unable to sign this form, he/she may have someone sign on his/her behalf.**

Signing for Applicant: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**The following portion must be completed by a Medical Professional**

Dear Medical Professional:

To process this applicant's request for Lake County Connection Paratransit Door-to-Door transportation services eligibility, we require this form to be completed.

Only a licensed Medical Professional having knowledge of the applicant's functional ability to use the LakeXpress fixed route bus service should complete this form. All LakeXpress fixed route vehicles are equipped with wheelchair lifts/ramps and the buses have automated enunciators which announces all major streets and intersections.

Please complete the section below. The information that you provide must be based solely upon the applicant having an actual physical or cognitive limitation which prevents the use of our LakeXpress fixed route service or operating a motor vehicle. The diagnosis of a potentially limiting illness or condition is not sufficient determination for paratransit services.

**THIS FORM MUST BE COMPLETED BY A MEDICAL PROFESSIONAL, AND MUST INCLUDE VALID MEDICAL LICENSE NUMBER, ADDRESS, PHONE NUMBER, AND SIGNED BY MEDICAL PROFESSIONAL.**

Patient's Name: \_\_\_\_\_

What is the applicant's disability? \_\_\_\_\_

How does the condition functionally prevent the applicant from using regular bus services  
\_\_\_\_\_

Is the condition permanent or temporary?  Permanent  Temporary

If temporary, what is the duration? \_\_\_\_\_

**Medical Professional Information:**

Signature of Medical Professional: \_\_\_\_\_ Date: \_\_\_\_\_

Medical License Number: \_\_\_\_\_ State Issued: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_ Suite #: \_\_\_\_\_ Bldg. #: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_ Extension: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email: \_\_\_\_\_ Contact Person: \_\_\_\_\_