

Applicant Name \_\_\_\_\_

**LAKE COUNTY CONNECTION - Application for ADA Paratransit Services**

**Instructions to Applicant or Proxy:**

1. Are you requesting transportation services for Dialysis or Chemo?  Yes  No
2. Please be sure to print and complete all information requested and sign where indicated.
3. The Medical Verification section must be completed and signed by an approved health care professional. In some instances, this requirement may be waived based on a functional assessment conducted by staff. All provided information will be verified and confirmed. You may attach supporting documentation.
4. Completing this application does not automatically certify you for ADA services. Applicants may be required to go through a functional assessment to assist us in determining your level of eligibility. All applicants will be notified of the outcome of their application.

If you would like to be notified by e-mail, please check this box.

**WHEN COMPLETED, PLEASE RETURN THIS FORM TO:**

Lake County Connection d/b/a	Telephone: (352) 742-2612
Lake County Transit Management, Inc.	Fax No.: (352) 508-5488
560 East Burleigh Blvd	E-mail: lctm@ratpdev.com
Tavares, FL 32778	

**OFFICE USE ONLY**

Date Received: \_\_\_\_\_ New Application:  Approved  Date: \_\_\_\_\_

Recertification:  Denied  Date: \_\_\_\_\_

Reason for Denial: \_\_\_\_\_  
\_\_\_\_\_

Reviewed By: \_\_\_\_\_ Funding Source: ADA

Applicant Notified By: \_\_\_\_\_ Date: \_\_\_\_\_

Method Used to Notify Applicant: Telephone  Mail   
E-mail  Other  \_\_\_\_\_

Last Name	First Name	Middle Initial	M/F	Date of Birth / /
Physical Address	Apt./Lot No.	City	State	Zip Code
Complex/Subdivision/Facility Name		Nearest Intersecting Street	Nearest Bus Route	
If this is a gated community, please provide gate code. _____				
Mailing Address	Apt./Lot No.	City	State	Zip Code
Home Phone	Work Phone	Cell Phone	E-mail Address	

**In case of emergency, please contact:**

Name	Relationship to You	Home Phone	Cell Phone	Work Phone
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If we are unable to reach the Primary Emergency Contact listed above, please provide a secondary emergency contact.

Name	Relationship to You	Home Phone	Cell Phone	Work Phone
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**Please check all that apply to you.**

<input type="checkbox"/> Portable Oxygen	<input type="checkbox"/> Assisted Walking	<input type="checkbox"/> Need Escort	<input type="checkbox"/> Wheelchair
<input type="checkbox"/> Visually Impaired	<input type="checkbox"/> Cane	<input type="checkbox"/> Crutches	<input type="checkbox"/> Walker
<input type="checkbox"/> Service Animal	<input type="checkbox"/> Stretcher	<input type="checkbox"/> Mental Impairment	<input type="checkbox"/> Hearing Impaired

**Functional Ability**

Without the assistance of someone else, can you:

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

Are you able to travel alone? \_\_\_ Yes \_\_\_ No

Do you currently use LakeXpress service? \_\_\_ Yes \_\_\_ No

(All buses are fully accessible with wheelchair lifts and many can kneel for easy access.)

If you do not use the LakeXpress service, please read the following statements and check 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 have to 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 conditions results in an impairment which makes it impossible for me to use regular bus service.

\_\_\_ I have an episodic disability. I can use the bus on those 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.

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### **Certification and Acknowledgement**

I understand and affirm that the information provided in this application for ADA transportation 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. I agree to notify Lake County Connection if there is any change in circumstances or I no longer need to use ADA services. I understand if I am approved for the ADA Program I must be recertified 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.

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Applicant's Signature

Date

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Signing for Applicant

Relationship

Date

**Applicant's Release**

I understand that the purpose of this evaluation form is to determine my eligibility for paratransit service. 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 any and all information regarding my medical condition to Lake County Connection. I understand that providing false or misleading information could result in my eligibility status being revoked. I agree to notify Lake County Connection within 10 days if there is any change in circumstances or I no longer need to use ADA 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 \_\_\_\_\_

Date \_\_\_\_\_

**MEDICAL VERIFICATION – To be completed by a licensed professional.**

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 fixed route bus service. The diagnosis of a potentially limiting illness or condition is not sufficient determination for paratransit services.

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

How does the condition functionally prevent the applicant from using regular bus service?

Is this condition permanent or temporary? Permanent \_\_\_\_ Temporary \_\_\_\_

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

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

Professional License Number \_\_\_\_\_ State Issued \_\_\_\_\_

Print Name \_\_\_\_\_

Address \_\_\_\_\_

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

Phone Number \_\_\_\_\_ Extension \_\_\_\_\_

Contact Person \_\_\_\_\_