BOARD OF COUNTY COMMISSIONERS
BROWARD COUNTY, FLORIDA

Americans with Disabilities Act (ADA)
Paratransit Application

Instructions for completing the Eligibility Application process

Please complete the application in its entirety, sign all the pages requiring your signature and return it to us by mail, or email at **Paratransit@broward.org**. Your **Florida licensed** healthcare provider most familiar with your disabling condition(s) is to complete and sign the Medical Verification form(s).

As part of the application process, 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 within 21 days of receipt of the completed application. You will receive this decision by mail. If a decision is not made within 21 days of receiving the completed application, the applicant shall be treated as eligible and shall have access to transportation service unless the application is denied.

If you need additional information, please contact customer service: 954.357.8400, 711 (TTY), or visit us on the web at: broward.org/BCT.

When complete you may mail the entire application to:

Broward County Transit - Paratransit Services
1 North University Drive, Suite 2400B
Plantation, FL 33324

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: _____
Assessment 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.

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

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

- ☐ Oxygen
- ☐ Cane
- ☐ Powered scooter
- ☐ Leg braces
- ☐ Walker
- ☐ Powered wheelchair
- ☐ Long white cane
- ☐ Crutches
- ☐ Manual wheelchair
- ☐ Service animal - Describe: _____
- ☐ 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)*

- ☐ Mobility
- ☐ Reading
- ☐ Transfers
- ☐ Medication
- ☐ 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 curb-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 legal guardian/power of attorney may signfor 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

SUBMIT A COPY OF YOUR CURRENT GOVERNMENT ISSUED PHOTO ID WITH THIS APPLICATION.

TOPS! Paratransit Eligibility
Medical Verification Forms

Please ask your Florida Licensed/Certified Heath 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 asapplicable:

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:_____