Smart City | Smart Transit | Moving Forward Together

TRANSPORTATION ASSISTANCE APPLICATION FOR PARATRANSIT SERVICE

Instructions to Applicant or Proxy:

- Please be sure to print, complete all information requested, provide copies of support material and sign where appropriate.
- The Medical Professional Verification (Section C) **must** be completed and signed by a licensed medical professional **(Physician, Nurse Practitioner, Physical Therapist, Clinical Social Worker or Certified Orientation and Mobility Specialist (COMS).**
- All information provided will be verified and confirmed. You may attach supporting documentation.

StarMetro provides Paratransit transportation in specially equipped vans to persons who cannot use the regular bus system. To be eligible for this service, individuals must have a disability that prevents them from using the regular fixed route bus system. Age, income, access, nor distances to the nearest bus stop are eligible disabilities by themselves. Riders under 13 years of age must travel with a Personal Care Attendant (PCA).

Determination of eligibility can take up to ten (10) business days. You will be notified by mail regarding your eligibility status. A new application, for recertification, is required every three (3) years with the exception of those customers with a permanent disability.

For your application to be evaluated and accepted, all requested forms and information must be complete when submitted. Incomplete applications will cause delays in eligibility approval. If assistance is needed in completing the application process, please call the CTC office at (850) 891-5199 or The Relay Service TDD at 711.

Mail or deliver completed application to:

StarMetro
Community Transportation Coordinator
555 Appleyard Dr.
Tallahassee, FL 32304
Phone: (850) 891-5199
Fax: (850) 891-5143
starmetro.customerservice@talgov.com

Persons giving false or misleading information to StarMetro in order to obtain transportation may be terminated from the program. All previous versions of this form are obsolete.

Please type or print when completing this form.

For Office Use Only	TRAPEZE ID # _____
☐ DAR	approver initials_____
☐ Non Sponsored	entered by _____

Date of Birth:_____/_____/_____ Social Security #:_____-_____-_____

Name: _____ ___M ___F
Last First Middle

Home Address: _____
Street Apt. # City State Zip Code

Phone #:_____
Home Work Cell Email Address

Mailing Address: _____
Street Apt. # City State Zip Code

Emergency Contact:_____
Name Relationship Daytime Phone

_____
Address Apt. # City State Zip Code

Check which condition(s) prevent you from accessing a regular StarMetro bus:

___My disability prevents me from using the fixed route bus system.
___ The nearest bus stop is more than five (5) blocks from my origin/destination.
___The bus does not operate where I travel.

Applicants Release of Information:

I understand that the purpose of this evaluation is to determine my eligibility for Paratransit services. The information about my disability contained in this application will be kept confidential and shared only with the professionals involved in evaluating my eligibility.
I hereby authorize my medical representative to release information regarding my functional ability to ride with StarMetro. I understand that providing false or misleading information could result in my eligibility status being revoked. I agree to notify StarMetro within ten (10) days of any change in my circumstances or I no longer need to use Paratransit services.

Signed_____Date_____/_____/_____
(Applicant's Signature)

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

Signed_____Date_____/_____/_____
(Signing for Applicant)

Name: _____

SECTION A

1. How far is the nearest bus stop? _____

2. Have you used StarMetro bus service in the past 6 month? Yes_____No_____
   If no, why not? _____

3. What are your transportation needs? _____

4. How do you currently travel to your destination? StarMetro bus:_____Taxi: _____
   Drive yourself:_____Other_____

5. Do you have weekly scheduled medical appointments (i.e. dialysis, etc.)?
   If yes, list: _____
   _____

6. How many medical appointments do you have a month?_____1-2 ____3-4 ____5-6
   more than 7 _____

7. Do you or anyone in your household have a car?_____Yes_____No
   (Information may be verified by the Florida Dept. of Motor Vehicles)

8. Do you have friends or relatives who can transport you?_____Yes_____No

Would you be interested in a low cost bus pass?_____Yes_____No

If yes, please request a bus pass application.

What conditions or elements prevent you from getting to and from a regular bus stop?

- ☐ There are no sidewalks
- ☐ The road is on an incline
- ☐ Extreme Weather
- ☐ Busy Intersection
- ☐ Ground is not level
- ☐ Other. Explain:_____

Name: _____

SECTION B

Functional Ability

Without the help of someone else, can you? (Please check yes or no)

	Yes	No		Yes	No
Cross a street?			Handle coins and transfers?		
Read/hear/understand directions?			Wait outside without support for 15 minutes or more?		
Travel one block on a sidewalk?			Grip handles or railings?		
Travel to the nearest bus stop?			Give your address and phone number?		
Walk ¾ of a mile?			Safely travel through crowded and/or complex facilities?		
Identify the correct bus?			Recognize a destination or landmark?		
Climb a 12-inch step?					

If you answered “no" to any of the above, please explain.

_____

_____

Please check all that apply to you:

- ☐ I am totally blind
- ☐ I am legally blind
- ☐ I have a vision impairment
- ☐ I have a hearing impairment
- ☐ I have a mental impairment
- ☐ I travel with a service animal
- ☐ I am on portable oxygen
- ☐ I travel by wheelchair
- ☐ I use a walker
- ☐ I use a cane
- ☐ I use crutches/leg brace

NOTE: Mobility devices that exceed 800 pounds when occupied may not be accommodated.

Name: _____

SECTION C

Medical Professional Certification

This section **must** be completed by a licensed medical professional.
(Physician, Nurse Practitioner, Physical Therapist, Licensed Clinical Social Worker)

Medical Professional's Name: _____

Office Address: _____

City: _____ State: _____ Zip _____

Office Telephone Number: _____

License/Certification No.: _____ State: _____

Profession: **Please check**

_____Physician _____Nurse Practitioner _____Physical Therapist

_____Licensed Clinical Social Worker _____Certified Orientation and Mobility Specialist

You must initial each statement to which you agree:

_____I certify that I have treated the Applicant and I am familiar with his/ her disability and/or health condition.

_____I certify that I have read and agree with the Applicant's information in its entirety.

_____I certify that the Applicant needs a Personal Care Attendant (PCA) when being transported. **If checked, the Applicant will not be able to travel alone.**

_____I certify that the Applicant is **unable** to ride StarMetro's fixed route (regular) bus service.

Please explain in detail why the applicant is **unable** to use the fixed route (regular) service:

_____

_____

If condition is not permanent, please indicate duration _____

I understand that false certification may be reported to the licensing jurisdiction under the State of Florida or appropriate code for state of license/certification.

_____ _____

Signature Date