



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 a signature, and return it by mail to the address below.

Approved riders **age 14 and older** may travel alone. Approved riders **age 13 and younger** and all riders with special medical needs must travel with a Personal Care Attendant (PCA). A PCA is an adult designated to help the applicant with their daily living needs. Pasco County Public Transportation (GoPasco) does not provide a PCA. If the applicant needs a PCA, please indicate so on the application.

Applicants may be required to attend an in-person functional assessment at a designated facility. If required, the applicant will be instructed how to complete the assessment. If an applicant does not have transportation to the assessment, GoPasco will provide it. After receiving the completed application, GoPasco will determine eligibility within 21 calendar days. Eligibility results will be sent to the applicant by mail. After 21-day, presumptive eligibility will be granted while the application process is completed.

Disability Verification by a qualified professional does not guarantee eligibility approval. It does play a major role in the eligibility determination process, though. The Florida licensed healthcare professional most familiar with the applicant's medical history should complete and sign Form A: General Medical Verification. **The medical professional must be able to determine the applicant's ability or inability to navigate GoPasco's regular fixed route bus system.** Qualified medical professionals include: Licensed Physicians (MD), Certified Rehabilitation Counselors, Physical Therapists, Occupational Therapists, or Orientation and Mobility Specialists. GoPasco may verify information provided by the healthcare professional.

GoPasco offers other Paratransit services based on an applicant's age, income, and access to transportation. To ensure the applicant receives all the services they qualify for, please complete the GoPasco ADA Paratransit Application and Form E Application for Other Paratransit Services.

All information provided to GoPasco is confidential and will not be shared with any other person or agency without written consent. For additional information, call GoPasco at **(727) 834-3322** or visit www.gopasco.com. Please mail the completed application to:

GoPasco
8620 Galen Wilson Boulevard
Port Richey, FL 34668

GoPasco

GoPasco ADA Paratransit Application

Received: _____ <small>MM/DD/YYYY</small>	Processed: _____ <small>MM/DD/YYYY</small>
Closest Bus Stop: _____ <small>FEET</small>	ADA Category 1 2 3 PCA H2H <small>CIRCLE ALL THAT APPLY</small>
Equipment: _____	ADA Conditions: _____
Reviewed By: _____	On: _____ <small>MM/DD/YYYY</small>
Approved for: <input type="checkbox"/> ADA <input type="checkbox"/> TD <input type="checkbox"/> III-B	
Approved: _____ <small>MM/DD/YYYY</small>	Expires: _____ <small>MM/DD/YYYY</small>

Client ID #: _____ New Applicant Recertification

PART I GENERAL INFORMATION

First Name: _____ MI: _____ Last Name: _____

Street Address: _____ Apartment: _____

Facility, Subdivision, or Community Name: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Gender: Male Female Other

Primary Phone: _____ Email Address: _____

Pasco Residency: Full Time Part Time Temporary

Emergency Contact (Required): _____ Relationship: _____

Primary Phone: _____ Mobile Phone: _____

If someone assisted the applicant with this form, please provide:

Name: _____ Primary Phone: _____

Is applicant a United States veteran? Yes No

Veterans ride free on GoPasco ADA Paratransit trips. To report veteran status, attach a copy of one of the following identification cards to this application (check ID used):

Military ID Card DD Form 2 VA Card State ID marked "V"

**This information is optional, used only for statistical reporting purposes; it is not used to determine eligibility for services. Check all that apply and fill in the blanks:*

American Indian Asian Black Hispanic Pacific Island White

Marital Status: _____ Cultural Considerations: _____

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AND PRIVACY POLICY

It is the policy of GoPasco to safeguard and keep confidential all information about any applicant or client of any service offered by GoPasco. This policy applies to any written, verbal, electronic, or other communications between GoPasco and any applicant or client. This policy applies to both personal and medical information. GoPasco will only give employees access to this information when they need it to make an eligibility requirement, provide paratransit service to the applicant, or when fulfilling regulatory reporting requirements.

The applicant acknowledges that GoPasco will not share the applicant's personal and medical information with any person or agency without their express written consent. GoPasco may verify the information provided in this application with the healthcare professional providing it.

By signing below, I acknowledge that I have read, understand, and received a copy of this notice.

Applicant Signature: _____ Date: _____

If the applicant is unable to sign any document in this application, the applicant's power of attorney may sign for the applicant and must provide proof of their power of attorney.

PART 2 INFORMATION ABOUT APPLICANT'S DISABILITY

1. Please checkoff all conditions that prevent the applicant from independently riding GoPasco's fixed route service. The applicant's healthcare provider will complete *Form A General Medical Verification*, verifying the conditions checked below.

<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Paraplegia
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> HIV/ AIDS	<input type="checkbox"/> Peripheral Vascular Disease
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Intellectual Disability	<input type="checkbox"/> Quadriplegia
<input type="checkbox"/> COPD	<input type="checkbox"/> Kidney Disease/ Dialysis	<input type="checkbox"/> Stroke/ Cerebral Trauma
<input type="checkbox"/> Cognitive Defect	<input type="checkbox"/> Lupus	<input type="checkbox"/> Thrombosis
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Visual Impairment
<input type="checkbox"/> Epilepsy/ Seizures	<input type="checkbox"/> Multiple Sclerosis	
<input type="checkbox"/> Surgery: Date _____ Type _____		
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	

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2. Check all mobility aids or medical devices used by the applicant:

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Oxygen | <input type="checkbox"/> Crutches | <input type="checkbox"/> White Cane |
| <input type="checkbox"/> Cane | <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Cue Cards |
| <input type="checkbox"/> Leg Braces | <input type="checkbox"/> Power Wheelchair | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Power Scooter | _____ |
| <input type="checkbox"/> Service Animal, Describe: _____ | | |

3. A **Personal Care Attendant (PCA)** is a responsible adult who helps another person with their **Activities of Daily Living (ADLs)**, including travel. PCAs are always allowed to travel with an eligible client free of charge when a medically justifiable need is established. GoPasco will not provide the applicant a PCA, nor will GoPasco drivers help clients with their ADLs. Does the applicant require the assistance of a PCA?

- Yes, a PCA is needed to help the applicant with (check all that apply):
- | | | |
|---------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Mobility | <input type="checkbox"/> Transfers | <input type="checkbox"/> Decision Making |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Navigation | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Other: _____ | | |
- No, the applicant does not need a PCA.

PART 3 QUESTIONS ABOUT USING GOPASCO FIXED-ROUTE BUSES

1. Has the applicant ever used GoPasco's Fixed Route buses? Yes No
2. If yes, enter the date the applicant last rode a GoPasco Fixed Route bus: _____
3. How many times has the applicant used a GoPasco Fixed Route bus during the last year? Never 1-12 Times 12-50 Times Over 50 Times
4. If the applicant was riding GoPasco's Fixed Route service and has since stopped, explain why: _____

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5. What will help the applicant ride a GoPasco Fixed Route bus? *(check all that apply)*

Communication aids.

Route and schedule information.

Being taught how to travel on the buses.

Having bus stops closer to home and destinations.

Other: _____

Nothing can help the applicant ride GoPasco's Fixed Route service.

6. Can the applicant ask for and follow written and/ or oral instructions to use a GoPasco Fixed Route bus? Yes No Sometimes

If the answer is *No* or *Sometimes*, check all that apply:

Applicant probably could ride bus if someone taught them how.

Other people cannot understand the applicant.

The applicant might get confused or lost riding the bus.

Other: _____

7. Can the applicant go to bus stops alone? Yes No Sometimes

If the answer is *No* or *Sometimes*, check all that apply:

Applicant probably could ride bus if someone taught them how.

Applicant gets confused and cannot find their way.

Applicant cannot travel outside when it is too hot.

Applicant cannot use streets or sidewalks that are too steep.

Applicant cannot cross busy streets and intersections.

Applicant cannot get to places without curb-cuts.

Applicant cannot see well at night.

Other: _____

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8. How far can the applicant travel on their own, with or without using a mobility aid device?

- Unable to leave residence alone.
- Able to travel from residence to front curb or driveway.
- Able to travel from residence to nearest bus stop.

9. Can the applicant wait outside up to 30 minutes for a GoPasco Fixed Route bus?

- Yes
- Yes, if they can sit
- Yes, if there is shelter
- No

10. Can the applicant use a ramp or lift to board a GoPasco Fixed Route bus?

- Yes
- No
- Sometimes
- I don't know

If *No* or *Sometimes* is checked, explain why: _____

11. Once onboard a GoPasco Fixed Route bus, can the applicant get to a seat or wheelchair position without help?

- Yes
- No
- Sometimes
- I don't know

If *No* or *Sometimes* is checked, explain why: _____

12. If the applicant can board a GoPasco Fixed Route bus, will they know where to get off the bus and can they find their way to their destination without assistance?

- Yes
- No
- Sometimes
- I do not know

If *No* or *Sometimes* is checked, explain why: _____

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13. Are there any other reasons why the applicant cannot ride a GoPasco Fixed Route bus? Please check all that apply:

Too much traffic No crosswalks No traffic lights to cross street

No curb cuts No or poor sidewalks Road construction

Too far to walk Cannot be in cold or hot weather over 30 minutes

Other reason: _____

14. If the applicant cannot tolerate cold or hot weather, state the coldest and warmest temperature they can tolerate, how long, and why: _____

15. Provide the names and address of places the applicant routinely goes to:

16. Provide other relevant information about the applicant that has not been asked:

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PART 4 COLLECTION OF SOCIAL SECURITY NUMBERS NOTICE (PROGRAM PARTICIPANTS)

Florida Statute 119.071(5) and Title 42 of the Code of Federal Regulations, Section 435.910 requires an agency collecting Social Security Numbers to provide a written explanation why they are collecting the Social Security Number.

Why is Pasco County Public Transportation collecting the applicant's Social Security Number?

Pasco County Public Transportation is collecting the applicant's Social Security Number as part of its responsibility to determine transportation eligibility. GoPasco does this to assess the applicant's eligibility for transportation services funded by state or federal government.

The provision of the applicant's Social Security Number is mandatory, and the applicant's information will remain confidential and protected under penalty of law. GoPasco will not use or give out the applicant's Social Security Number for any reason other than to determine the applicant's eligibility for transportation services. GoPasco will not give the applicant's Social Security Number to other agencies unless the applicant has signed a separate form consenting to the release of information to another agency.

Affidavit:

I understand and affirm that the information provided in this application is truthful and accurate to the best of my knowledge and authorize the release of this information to GoPasco for the purpose of evaluating my eligibility to participate in the Paratransit services program. I understand that providing false or misleading information, or making fraudulent claims, or making false statements on behalf of others constitutes a felony under the laws of the State of Florida. I agree to notify GoPasco of any changes in my status immediately and understands that this may affect my eligibility to use these services. I understand the reason why Pasco County Public Transportation collects my Social Security Number.

Applicant's Social Security Number: _____

___ *By checking this statement, I state that I refuse to provide my Social Security Number. I understand that I will not be considered for any Paratransit service that requires a Social Security Number. I would like to be considered for other services that do not require one and have completed Form E Application for Other Paratransit Services.*

Applicant Signature: _____ Date: _____

If the applicant is unable to sign, the applicant's power of attorney may sign for the applicant and must provide proof of their power of attorney.

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PART 5 APPLICANT CERTIFICATION

By signing below, the applicant affirms the information provided in the Application is correct to the best of their knowledge.

Affidavit:

I understand the purpose of this application is to help GoPasco determine if there are times when I cannot use the GoPasco fixed route bus service and must use Paratransit services. I certify, to the best of my knowledge, that the information in this application is true and correct. I understand that 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 Signature: _____ Date: _____

If the applicant is unable to sign, the applicant's power of attorney may sign for the applicant and must provide proof of their power of attorney.

Please attach a copy of the applicant's valid government photo identification to this application. Acceptable forms include a state issued driver's license, a state issued identification card, a U.S. military issued identification card, or a passport.

PART 6 APPLICANT MEDICAL INFORMATION RELEASE AUTHORIZATION

By signing below, I give permission to my Healthcare Provider(s) to release my medically protected information to Pasco County Public Transportation, for the sole purpose of determining my eligibility to receive GoPasco Paratransit services.

Applicant Signature: _____ Date: _____

If the applicant is unable to sign, the applicant's power of attorney may sign for the applicant and must provide proof of their power of attorney.

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PART 7 GoPASCO PARATRANSIT ELIGIBILITY MEDICAL VERIFICATION FORMS

Please ask the applicant's Florida Licensed or Certified Healthcare Provider to complete the medical form that best describes the applicant's need for Paratransit services.

Note to Healthcare Provider:

By completing and signing the Paratransit Eligibility Medical Verification Forms, the healthcare provider certifies the truth and accuracy of the information provided on the application, to the best of their professional knowledge. The Americans with Disabilities Act of 1990 requires GoPasco to provide services to persons who are unable to use GoPasco's Fixed Route bus service due to a disability. The information the healthcare provider allows GoPasco to make an appropriate evaluation of the applicant's eligibility.

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

1. Individuals who, as a result of a physical or mental impairment (including visual impairments) and without the assistance of another individual (except the bus operator), cannot board, ride, or disembark from an accessible transit bus or vehicle.
2. Individuals who can independently use an accessible transit bus or vehicle, but none are available on their route (all GoPasco buses are ADA complaint).
3. Individuals who have a specific impairment-related condition that prevents them from getting to or from a posted GoPasco Fixed Route bus stop.

Anyone applying for ADA Paratransit service must submit Form A: General Medical Verification. Applicants may, but are not required, to submit the following forms as well:

- Form B Visual Impairment Verification
- Form C Epilepsy or Seizure Disorders Verification
- Form D Cognitive or Mental Health Conditions Verification

All applicants should complete Form E Application for Other Paratransit Services. The more services an applicant qualifies for, the more flexibility they have when riding a GoPasco Paratransit service.

Please attach all original signed Medical Verification Forms to this Application before submitting to Pasco County Public Transportation for an eligibility determination.

GoPasco ADA Paratransit Application

Form A General Medical Verification

The Florida licensed healthcare professional most familiar with the applicant's medical history should complete and sign this form. ***The medical professional must be able to determine the applicant's ability or inability to navigate Pasco County Public Transportation's (GoPasco) Fixed Route bus system.*** Qualified medical professionals include:

- Licensed Physicians (MD)
- Certified Rehabilitation Counselors
- Physical Therapists
- Occupational Therapists
- Orientation and Mobility Specialists.

Please explain how the applicant's disability prevents them from using GoPasco's Fixed Route bus service independently. To learn more about GoPasco's service, please visit www.gopasco.com or call 727-834-3322 to speak with a representative.

Please note, all GoPasco fixed route buses are 100% accessible to people with disabilities as required by Federal Transit Authority Circular 4710.1 Americans With Disabilities Act (ADA): Guidance. This document can be found at:

https://www.transit.dot.gov/sites/fta.dot.gov/files/docs/Final_FTA_ADA_Circular_C_4710.1.pdf.

Applicants Name: _____ Date of Birth: _____

1. Date of onset of qualifying disability or medical condition: _____

2. Is applicant's functional limitation permanent? Yes No

If No, what is the expected duration (years and/ or months): _____

GoPasco will not provide a Personal Care Attendant (PCA), nor will GoPasco drivers help clients with their Activities of Daily Living. Does the applicant need a PCA to safely ride a GoPasco Paratransit vehicle? Yes No If Yes, explain why:

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Form A General Medical Verification

GoPasco Paratransit provides door-to-door service. We will pick up a client at a departure point door, drive to a destination, then deliver them to the destination door. Our drivers do assist passengers on to and off the vehicles, which includes securing wheelchairs and other mobility devices and stowing packages. Drivers do not enter buildings or contact on-sight staff members on behalf of the client.

Can the applicant safely be left unattended at a pickup or drop-off locations

Yes No If No, explain why: _____

Please provide any other information that may help GoPasco determine the applicant's eligibility for Paratransit service: _____

I certify the information provided above is correct.

Signature of Licensed Healthcare Provider

Date

Please print your contact information below:

Name: _____

Phone: _____

Business Address: _____

Florida Board Certificate or License Number: _____

GoPasco ADA Paratransit Application

Form B Visual Impairment Verification

Please explain how the applicant's visual impairment prevents them from using GoPasco's Fixed Route bus service independently.

Applicants Name: _____ Date of Birth: _____

1. Please state applicant's Visual Impairment: _____

2. Corrected Visual Acuity: OS _____ OD _____

3. Date of onset: _____

4. Is applicant's functional limitation permanent? ___ Yes ___ No

If No, what is the expected duration (years and/ or months): _____

5. Explain how the applicant's visual disability, combined with any environmental barriers, prevents their independent use of GoPasco's Fixed Route bus service:

6. GoPasco will not provide a Personal Care Attendant (PCA), nor will GoPasco drivers help clients with their Activities of Daily Living. Does the applicant need a PCA to safely ride a GoPasco Paratransit vehicle? ___ Yes ___ No

If Yes, explain why:

7. GoPasco Paratransit drivers do not enter buildings or contact on-sight staff members on behalf of a client. Can the applicant safely be left unattended at pickup or drop-off locations? ___ Yes ___ No If No, explain why: _____

I certify the information provided above is correct.

Signature of Licensed Healthcare Provider

Date

Please print your contact information: Name: _____

Phone: _____ Business Address: _____

Florida Board Certificate or License Number: _____

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Form C Epilepsy or Seizure Disorders Verification

Please explain how the applicant's epilepsy or seizure disorder prevents them from using GoPasco's Fixed Route bus service independently.

Applicants Name: _____ Date of Birth: _____

1. Type of Seizure: _____ Frequency: _____

2. Does the seizure alter consciousness or awareness? ___ Yes ___ No

3. Is applicant's functional limitation permanent? ___ Yes ___ No

If No, what is the expected duration (years and/ or months): _____

4. Explain the behaviors exhibited by the applicant during and following a seizure:

5. Would applicant be able to travel independently on fixed-route buses if they are medication compliant? ___ Yes ___ No

6. GoPasco will not provide a Personal Care Attendant (PCA), nor will GoPasco drivers help clients with their Activities of Daily Living. Does the applicant need a PCA to safely ride a GoPasco Paratransit vehicle? ___ Yes ___ No If Yes, explain why: _____

7. GoPasco Paratransit drivers do not enter buildings or contact on-sight staff members on behalf of a client. Can the applicant safely be left unattended at pickup or drop-off locations? ___ Yes ___ No If No, explain why: _____

I certify the information provided above is correct.

Signature of Licensed Healthcare Provider

Date

Please print your contact information: Name: _____

Phone: _____ Business Address: _____

Florida Board Certificate or License Number: _____

GoPasco ADA Paratransit Application

Form D Cognitive or Mental Health Conditions Verification

Please explain how the applicant's cognitive or mental health prevents them from using GoPasco's Fixed Route bus service independently.

Applicants Name: _____ Date of Birth: _____

1. Applicant's DSM-5 diagnoses: _____ Date of Onset: _____

2. Does the disability alter consciousness or awareness? ___ Yes ___ No

3. Is applicant's functional limitation permanent? ___ Yes ___ No

If No, what is the expected duration (years and/ or months): _____

4. Check any of the following that is affected by the individual's disability:

<input type="checkbox"/> Orientation	<input type="checkbox"/> Concentration	<input type="checkbox"/> Monitoring Time
<input type="checkbox"/> Problem Solving	<input type="checkbox"/> Coping Skills	<input type="checkbox"/> Judgment
<input type="checkbox"/> Communication	<input type="checkbox"/> Gait or Balance	<input type="checkbox"/> Consistency
<input type="checkbox"/> Social Behavior	<input type="checkbox"/> Aggression	<input type="checkbox"/> Performance
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Short Term Memory	<input type="checkbox"/> Long Term Memory

Other: _____

5. Would applicant be able to travel independently on fixed-route buses if they are medication compliant? ___ Yes ___ No

6. GoPasco will not provide a Personal Care Attendant (PCA), nor will GoPasco drivers help clients with their Activities of Daily Living. Does the applicant need a PCA to safely ride a GoPasco Paratransit vehicle? ___ Yes ___ No If Yes, explain why: _____

7. GoPasco Paratransit drivers do not enter buildings or contact on-sight staff members on behalf of a client. Can the applicant safely be left unattended at pickup or drop-off locations? ___ Yes ___ No If No, explain why: _____

I certify the information provided above is correct.

Signature of Licensed Healthcare Provider

Date

Please print your contact information: Name: _____

Phone: _____ Business Address: _____

Florida Board Certificate or License Number: _____

GoPasco ADA Paratransit Application

Form E Application for Other Paratransit Services

GoPasco offers other Paratransit services based on an applicant's age, income, and access to transportation. Applicants may receive reduced fare or free rides, depending on qualifications and rides available at the time. When a client qualifies for other Paratransit services, GoPasco informs the client of their fare when the reservation is made. To ensure the applicant receives the services they qualify for, please complete all this form.

Applicants Name: _____ Date of Birth: _____

Annual Household Income: _____ Income Sources: _____

Including Applicant, total number of people in household (complete details below): _____

<u>Name</u>	<u>Relationship to Applicant</u>	<u>Age</u>	<u>Licensed to Drive</u>	<u>Vehicle Type Owned</u>
_____			<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____			<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____			<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____			<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____			<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Does Applicant own a vehicle? Yes No If Yes, what type? _____

Does any member of the household own a vehicle? Yes No Who? _____

How does the Applicant currently get to appointments and shopping? _____

List any other programs Applicant is enrolled in that provides transportation: _____

Can Applicant easily transfer from a wheelchair to a car? Yes No N/A

If Applicant uses a wheelchair, what are the dimensions? _____

What is the combined weight of the wheelchair and Applicant? _____

Is wheelchair equipped with a seatbelt? Yes No N/A

Can Applicant climb 3 12-inch steps into bus with handrails? Yes No Sometimes

If checked *No* or *Sometimes*, please explain: _____

Applicant Signature: _____

Date: _____