PASCO COUNTY FLORIDA
OPEN SPACES. VIBRANT PLACES.

West (727) 834-3322
Central (813) 235-6073
East (352) 521-4587
Fax (727) 859-0589
TTY Access 7-1-1

Date:_____

Dear Transportation Applicant:

Enclosed you will find a Pasco County Public Transportation (PCPT) application for Paratransit services. Please complete the attached application, sign and mail the application back to PCPT at the address on the form.

PCPT will use this form to assess your transportation needs and to determine your eligibility for transportation within our various transportation opportunities. PCPT will notify you of the review findings, within twenty-one (21) days of receipt of your completed application.

If you do not receive any response within 20-days you returning this application, please contact PCPT at 727-834-3322 to follow up on your application.

If you have any questions or concerns, please call PCPT at 727-834-3322.

Respectfully,

Kurt M. Scheible
Public Transportation Director

PASCO COUNTY PUBLIC TRANSPORTATION (PCPT)

8620 Galen Wilson Boulevard
Port Richey, Florida 34668
(727) 834-3322

FOR OFFICIAL PCPT USE ONLY

Eligible for ADA: _____

Eligible for TD _____

Eligible for III-B _____

Eligible for CDBG _____

ELIGIBILITY APPLICATION FOR PARATRANSIT SERVICES

First Name _____Middle Initial ____Last Name _____ Social Security #_____

Street Address Apt #

City State County Zip

Name of Condo/Apartment, Sub-Division or Mobile Home Park

Closest Major Intersection

Telephone (home) (work) Date of Birth Sex (M) (F)

*The information below is optional and is used for statistical reporting purposes only. It is not used to determine eligibility for service.

*Race/Ethnicity: American Indian _____ Asian or Pacific Indian _____ Black, Not Hispanic Origin _____
Hispanic_____ White, Not Hispanic Origin _____

* Any Cultural Considerations _____

*Marital Status

Household Yearly Income Source of Income Number in Household

Other Household Members (Please list each member) Name Relationship Age Driv. Lic.(Y/N) Type of Vehicle

Do you own a vehicle? Yes____ No ____ Do you have a Driver's License? Yes ____ No____
Type of vehicle (car/van, etc) _____ Does any member of your household own a vehicle? Yes ____ No ____
Do you have friends or family members in the County who can transport you? Yes ____ No____ If not, why?

Please list all Hospitals, Doctors and Medical Facilities that you visit on a regular basis:

NAME OF HOSPITAL/DOCTOR/FACILITY	NUMBER OF TYPE OF TREATMENT	DESCRIBE MONTHLY VISITS	HOW YOU PREVIOUSLY GOT THERE

AVAILABILITY OF FEDERALLY FUNDED OR PUBLIC TRANSPORTATION

Yes / No

1. _____Do you live on a bus route? What is the distance to the nearest bus stop? _____
2. _____Have you used the bus system for transportation in the past?
3. _____Do you have any limitations that would prevent you from using the bus system now?
   If YES, please describe your limitations below. Be specific.

_____

_____

4._____ Are you enrolled in any other programs that will pay for or provide transportation? If YES, please describe them below.

_____

SPECIAL NEEDS

Please check or list any special needs, services or modes of transportation you require during transportation:

_____Powered Wheelchair/Scooter_____ Manual Wheelchair_____Walker_____Cane

_____Respirator/Portable Oxygen_____Service Animal_____Personal Care Attendant (PCA)_____Cue Cards

Other: _____

- Are you able to transfer from your wheelchair to a car easily?
  _____Yes _____No _____Not Applicable

  If yes:_____Independently _____Only with assistance

- Wheelchair Dimensions_____Combined weight of chair and passenger ____
  Is wheelchair equipped with seat belts?_____Yes _____No
  Other (please identify): _____

  _____

- Can you climb three 12-inch steps to board a bus that has handrails?
  _____Yes _____No _____Sometimes
  If no or sometimes, please explain.

  _____

  _____

- Some bus trips may require you to get off one bus and onto another to complete your trip. Can you do this on your own? _____ Yes_____No _____Sometimes
  If no or sometimes, please explain.

  _____

  _____

- _____My disability prevents me from getting to the bus stop.
  _____ I could use the regular PCPT fixed route bus after receiving travel training.
  _____ I can use the regular PCPT fixed route bus under certain circumstances. Please explain.

  _____

  _____

- In case of an evacuation would you need transportation to a shelter? _____Yes _____No
  If so, call and register with the SPECIAL NEEDS ASSISTANCE POPULATION PROGRAM (SNAPP) at (727) 847-8956 or (352) 521-5137.

- Please provide the name, address and phone number of an **emergency contact person**:

  _____

  _____

- Is your health condition or disability temporary? _____ Yes _____ No
  If yes, expected duration until ____/_____/_____ (_____ months)

- PCPT's regular bus drivers call out bus stops at major transfer and destination points and all major intersections. They will also call out special stops upon request. With this help, can you recognize the right stop and get off the bus when you need to? _____ Yes_____No _____Sometimes
  If no or sometimes, please explain.

  _____

  _____

- Using a mobility aid, or on your own, how far are you able to travel without the assistance of another person?
  _____½ block (Less than 200 ft.) _____1 or 2 blocks (circle one) _____¼ mile (3 blocks)
  _____½ mile (6 blocks) _____¾ mile (9 blocks) _____Other (please explain)

  _____

  _____

NOTE: If someone other than the applicant has completed this form please provide the appropriate information in the space below.

_____

Name Relationship to Applicant

_____

Address City State Zip

_____

Daytime Telephone

_____

This information is available in an accessible format upon request. To request these formats, please contact PCPT.

I understand that the information obtained in this certification process will only be used by *PCPT* to determine eligibility for Paratransit services, and that this information will only be shared with other transit providers or transportation programs to facilitate travel and/or coordinate services. This information will be kept confidential and will NOT be utilized for any other purpose, unless so

authorized by the applicant in writing or unless otherwise ordered released by a court of law or equity. However, I understand that PCPT may need to contact an authorized professional to verify the information on this application regarding how my status prevents me from using the *PCPT* fixed route schedule bus system.

Collection of Social Security Numbers Notice
(Program Participants)

Florida Statute 119.071(5) and Title 42 Code of Federal Regulations, Section 435.910, require any agency that collects Social Security numbers to provide a written explanation to the individual of the reason for its collection.

Why is Pasco County Public Transportation collecting your Social Security Number?

Pasco County Public Transportation is collecting your Social Security number as part of its responsibility to determine transportation eligibility. We do this to assess transportation services that are funded by the state or federal government for which you may qualify.

The provision of your Social Security number is mandatory and your information will remain confidential and protected under penalty of law. We will not use or give out your Social Security number for any other reason, including referrals to other agencies, unless you have signed a separate form consenting to the release of information to another agency.

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 PCPT 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 the *PCPT* office of any changes in my status immediately and understand that this may affect my eligibility to use these services. I understand the reason why Pasco County Public Transportation collects my Social Security number.

Please sign and return with your CDBG Self-Certification form.

Applicant Signature _____ Date _____

DISABILITY VERIFICATION

Disability verification by a qualified professional does not guarantee eligibility, but it can play a major role in the eligibility determination process. It is important that any professional that verifies an individual's disability be familiar not only with that person's particular disability, but with the individual's ability or inability to travel on PCPT's regular fixed route bus system.

Please have the following Request for Verification of Disability form completed by one of the health care professionals listed below and return it with the completed application.

Licensed Physician (MD) Physical Therapist Occupational Therapist
Certified Rehabilitation Counselor Orientation and Mobility Specialist

I understand that this information is confidential and will not be shared with any other person or agency, with the possible exception of another transit provider or transportation program to facilitate travel in those areas. **PCPT may verify this information with the health care professional.**

PASCO COUNTY PUBLIC TRANSPORTATION
(***PCPT***)
8620 GALEN WILSON BOULEVARD
PORT RICHEY, FLORIDA 34668
(727) 834-3200

REQUEST FOR VERIFICATION
OF DISABILITY

Dear Medical Provider:

Patient Name: _____

This form is necessary for the above named patient to utilize our transit services. He/she has indicated that you can verify his/her disability and its impact upon his/her ability. Federal law (the Americans with Disabilities Act of 1990) requires Pasco County Public Transportation (*PCPT*) to provide Paratransit services to persons who cannot utilize available fixed route services. The information you provide will allow us to make an appropriate evaluation of this request and its application to specific trip requests. Thank you for your cooperation in this matter.

NOTE: Disability verification is mandatory for all applicants for *PCPT* service. Any professional that verifies an individual's disability, must have detailed, first-hand knowledge of that person's disability, as well as the training and credentials necessary for such an evaluation.

- Please describe your professional status; i.e., Licensed Physician, Physical Therapist, Occupational Therapist, Specialist and describe your methods for evaluating the applicant's disability.

  _____

  _____

  _____

- Medical/functional condition causing the disability, which will prevent the individual from using the regular bus service.

  _____

  _____

  _____

- Is this condition temporary? _____ Yes _____ No

  If yes, expected duration until ____/_____/_____

PHYSICAL DISABILITIES

- If the person has a disability affecting mobility, is the person able to travel either on his/her own or with a mobility aid 200 feet without the physical assistance of another person?
  _____Yes _____No _____Sometimes

- Is the person able to travel either on his/her own or with a mobility aid 200 yards without the physical assistance of another person?
  _____Yes _____No _____Sometimes

- Is the person able to travel either on his/her own or with a mobility aid ¼ mile without the physical assistance of another person?
  _____Yes _____No _____Sometimes

- Is the person able to climb three (3) 12-inch steps without the assistance of another person? (Handrails are available)
  _____Yes _____No _____Sometimes

- Is the person able to wait outside without support for ten (10) minutes?
  _____Yes _____No _____Sometimes

- Does this person require special assistance and /or the use of any mobility aids? If so, what?

  _____

  _____

- Are there any circumstances in which the applicant could not ride the regular, lift-equipped PCPT buses? Please describe.

  _____

  _____

- Does this person require a Personal Care Attendant (PCA) when traveling on public transit?
  _____Yes _____No _____ Sometimes (describe)

  _____

  _____

- If this person falls, can he/she get up independently? _____Yes _____No _____Sometimes

- Can this person negotiate traffic safely and independently? _____Yes _____No _____Sometimes

- Can this person read information signs? _____Yes _____No
  If no, please explain.

  _____

  _____

- **NOTE: PCPT must be made aware of any special requirements of eligible passengers particularly if traveling with a respirator or portable oxygen supply. Please describe if applicable.**

  _____

  _____

  _____

- If there is any other effect of the disability of which PCPT should be aware, please describe (e.g., heat sensitivity, etc.).

  _____

  _____

  _____

Name of Professional

_____

Mailing Address

_____

City State Zip

_____

Telephone Number

_____

Signature: _____ Date: _____

PASCO COUNTY CDBG PROGRAM ADMINISTRATION

Self-Certification Form for Eligibility of Service

The information requested below is required to determine if you are eligible for the service or program, funded with Community Development Block Grant (CDBG) funds, disbursed by the US Department of Housing and Urban Development (HUD).

Information provided in this form is strictly confidential and will not be released to anyone other than the Pasco County CDBG Program Administrator and Pasco County Public Transportation (PCPT) staff responsible for collecting this information.

Any questions call PCPT (727) 834-3322, (813) 235-6073 or (352) 521-4587.

1. Name of Applicant: _____

2. Street Address: _____

3. City: _____

4. State: _____

5. Zip: _____

6. County of Residence: _____

7. Number of Persons in your household including yourself:

# of Adults in Household	# of Children in Household	# of Elderly in Household	# of Disabled in Household	**TOTAL # OF PERSONS IN HOUSEHOLD**

8. Total household income (adjusted gross income) earned by all adults 18 years and older?

Income Source	**Total Yearly Income**	**Total Monthly Income**	**Total Weekly Wages**	**No Income**

9. Ethnicity (select only one):

Ethnicity	**Select one**
Hispanic or Latino	☐
Non-Hispanic or Non-Latino	☐

10. Race (select only one):

Race	**Select one**
White	☐
Black / African American	☐
Asian	☐
American Indian/Alaskan Native	☐
Native Hawaiian or Other Pacific Islander	☐
White & Asian	☐
White & Black/African American	☐
Black/African American & American Indian/Alaskan Native	☐
Other Multiracial	☐

PASCO COUNTY CDBG PROGRAM ADMINISTRATION

Self-Certification Form for Eligibility of Service

11. Do you or any of your household members belong to one or more of the following categories?

Special Needs Categories	Check applicable box(es)	Person(s) in Category
Elderly Person (62 years or older):	☐	
Homeless:	☐	
Disabled:	☐	
Severely Disabled:	☐	
Illiterate:	☐	
Battered Spouse:	☐	
Abused Minor:	☐	
AIDS Patient:	☐	
Migrant Farm Worker:	☐	
Part of female-headed Household: (where the primary wage-earner is a woman):	☐	
TOTAL PERSONS LIVING IN HOUSEHOLD		

I hereby certify that the above information is true and correct to the best of my knowledge. I understand that any benefit received by me or my household through Community Development Block Grant (CDBG) funds is contingent upon meeting the above eligibility requirements. I also understand that this information may be verified, and I authorize the release of any information required to verify this information. If this information cannot be verified as true and correct, I understand that it may exclude me and/or my household for receiving the above mentioned service. I may be required to repay funds received through the CDBG program administration if I fail to provide true and correct information to qualify me or my household for this program.

_____ _____

Signature Date

FY 2015 Income Limits Documentation System

FY 2015 Income Limits Summary

FY 2015 Income Limit Area	Median Income Explanation	FY 2015 Income Limit Category	Persons in Family 1	2	3	4	5	6	7	8
Pasco County	$59,000	Very Low (50%) Income Limits ($) Explanation	20,650	23,600	26,550	**29,500**	31,900	34,250	36,600	38,950
		Extremely Low Income Limits ($)* Explanation	12,400	15,930	20,090	**24,250**	28,410	32,570	36,600*	38,950*
		Low (80%) Income Limits ($) Explanation	33,050	37,800	42,500	**47,200**	51,000	54,800	58,550	62,350

Health Insurance Portability and Accountability Act (HIPAA)

Pasco County Public Transportation (PCPT) and the contract providers will comply with all requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996's Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule"). As such, each agrees to the following:

A. That neither party will use or disclose protected health information for any purpose other than as authorized by law, by this contract, or by separate agreement between the parties.

B. That each party will not use or disclose protected health information in a manner which would be a prohibited use or disclosure if made by the other.

C. That each party will maintain safeguards as necessary to ensure that the protected health information is not used or disclosed except as provided by law, by this contract, or by separate agreement between the parties.

D. That each party will report to the other any use or disclosure of the protected health information of which it becomes aware that is not provided for by law, by this contract, or by separate agreement between the parties.

E. That each party will ensure that any of its subcontractors or agents to whom it provides protected health information received from the other agree to the same restrictions and conditions that apply to each other with respect to such information.

F. That each party will follow an agreed upon process established to provide access to protected health information to the subject of that information when the other has made any material alteration to the information. This process will include how each party would determine in advance how the other would know or could readily ascertain when a particular individual's protected health information has been materially altered by the other and how it could provide access to such information. This process will establish how each party would provide access to protected health information to the subject of the information in circumstances where the information is being held by the other.

G. That each party will provide health information to the subject of the information in accordance with the subject's right to access, inspect, copy, and amend their health information.

H. That each party will make available to the other its internal practices, books and records relating to the use, disclosure, and tracking of disclosure of protected health information received from the other or its agents for the purposes of enforcing compliance with HIPAA.

I. That each party will assist the other in meeting its obligation to provide, at an individual's request, an accounting of all uses and disclosures of personal health information which are not related to treatment, payment, or operations within sixty (60) days of the request of an accounting.

J. That each party will incorporate any amendments or corrections to protected health information when notified by the other that the information is inaccurate or incomplete.

K. That at the termination of this contract, unless a new contract is agreed upon, each party will return or destroy all protected health information received from the other that it still maintains in any form.

L. That either party may terminate this contract if it learns that the other has repeatedly violated a term of this contract provision.

M. That each party will disclose only the minimum amount of information necessary to accomplish the permitted use of the protected health information. This minimum use requirement does not apply to information provided for treatment or to disclosures required by law.

N. That each party will limit the use and disclosure of protected health information to the minimum number of employees necessary by class of employee and type of information to accomplish the permitted use of the information.

O. That each party will meet at least the minimum security requirements for the protection of protected health information as required by HIPAA.

P. That each party is bound by the terms of the "Notice of Practices" of the other with regard to protected health information it receives from the other.