_____

Applicant Name

LAKE COUNTY CONNECTION
Application for Paratransit Services

Please check the program you are applying for. Applications may be approved for one or two years, depending on the service that you are applying for.

___ Transportation Disadvantaged ____ ADA ____ Both

Instructions to Applicant or Proxy:

1. Please be sure to print and complete all information requested and sign where indicated.
2. **IF YOU ARE APPLYING FOR ADA,** 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.
3. Completing this application does not automatically certify you for paratransit 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
P.O. Box 491597
Leesburg, FL 34749

Telephone: (352) 326-2278
Fax No. (352) 365-2982
E-mail: LakeCounty97@mvtransit.com

OFFICE USE ONLY

Date Received: _____ **New Application:** ☐ **Approved** ☐ **Date:** _____

Recertification: ☐ **Denied** ☐ **Date:** _____

Reason for Denial: _____

_____

Reviewed By: _____ **Funding Source:** **ADA** ☐ **Medicaid** ☐

FDOT ☐ **TD** ☐

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 Social Security Number (Medicaid recipients only.) Medicaid Number

Home Address Apt./Lot No.

City County State Zip Code

Complex/Subdivision/Facility Name Nearest Intersecting Street Nearest Bus Route

If this is a gated community, please provide gate code. _____

Home Phone Work Phone Cell Phone E-mail Address

Mailing Address Apt./Lot No. City County State Zip Code

In case of emergency, please contact:

Name Relationship to You Home Phone Cell Phone Work Phone

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

Please check all that apply to you.

___ Portable Oxygen ___ Assisted Walking ___ Needs Escort ___ Wheelchair

___ Sight Impairment ___ Cane ___ Crutches ___ Walker

___ Service Animal ___ Stretcher ___ Mental Impairment ___ Hearing Loss

Do you have weekly scheduled medical appointments? Yes ____ No ____

How many medical appointments do you have in a month? ____

How do you currently travel to your destination?

____ Bus ____ Taxi ____ Drive Yourself ____ Other (Please explain)_____

What prevents you from driving your car? _____

Do you have relatives or friends who can transport you? Yes ____ No ____

What are the names and ages, including yourself, of the people living in your household?

_____

(Does not apply if you are applying for ADA only.)

Does anyone living in your household own a car? Yes ____ No ____
(Does not apply if you are applying for ADA only.)

What is the **combined** monthly household income of everyone living in the home? _____
(Does not apply if you are applying for ADA only.)

Are you currently receiving public assistance such as food stamps? Yes ____ No ____
(Does not apply if you are applying for ADA only.)

Monthly Income (Does not apply if you are applying for ADA only.) **In order to process your application, proof of income must be submitted with your application**.

Salary $_____ SSI $_____ Retirement $_____ Other $_____

Monthly Expenses (Does not apply if you are applying for ADA only.) **If you are a roomer or boarder you must provide a notarized statement from your landlord listing the amount you pay for board, utilities and meals**.

Housing $_____ Utilities $_____ Vehicle $_____ Food $_____ Cable $_____

Phone $_____ Cell Phone $_____ Medical $_____ Pharmacy $_____ Fuel $_____

Home Insurance $_____ Car Insurance $_____ Other $_____

Total Monthly Household Expenses $_____

Would you ride LakeXpress if you were provided with a free bus pass? Yes ____ No ____

What is the location of the bus stop nearest to your home? _____

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__	

Please check the condition(s) which prevents you from accessing a regular LakeXpress fixed route bus.

____ None

____ The bus stop is too far or the bus does not run where I need to go.

____ My disability prevents me from using the regular fixed route bus system.

____ I need transportation to and from medical appointments outside of Lake County.

Certification and Acknowledgement

I understand and affirm that the information provided in this application for Non-Emergency Transportation Disadvantaged 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 paratransit services. I understand if I am approved for the Transportation Disadvantaged Program I must be recertified one year from the date of approval for services and if I am approved for the ADA Program I must be recertified in two years from date of approval.

Lake County Board of County Commissioners and our Operator, MV Transportation, 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.

_____

Applicant's Signature Date

_____

Signing for Applicant Relationship Date

THIS FORM IS TO BE USED ONLY IF YOU ARE APPLYING FOR THE ADA PROGRAM.

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 paratransit 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 _____