

# Lakeland Area Mass Transit District

## ADA Application

- I. Instructions to Applicant or Representative:
  - Please read the enclosed Paratransit eligibility criteria carefully. If you believe that you meet **all** the criteria, please fill out the Applicant sections of the form.
  - Be sure to print and complete **all** information requested and sign where indicated.
  - Have the Health Care Professional sections completed and signed by an approved health care professional. **All provided information will be verified and confirmed.** You may attach supporting documentation. Your Health Care Professional may require that you sign an authorization for him/her to release your private medical information.
  - If you have any questions, please contact Polk County Transit Services at (863)534-5500, Monday through Friday between 8:00 a.m. and 5:00 p.m.
  
- II. Instructions to Health Care Professional:

The Applicant is requesting certification to use ADA Paratransit service. ADA Paratransit is a door-to-door, shared ride program for individuals with physical or cognitive disabilities who are unable to use or access the fixed-route public transportation system, such as Winter Haven Area Transit or Citrus Connection and is in compliance with the Americans with Disabilities Act (ADA) of 1990.

Please complete the medical verification sections of this application. The information you provide must be based solely upon the individual=s physical or cognitive ability to use or access public transportation. Considerations based on the individual=s age and/or the economic status of the applicant will not be used as certification for this service. Federal law is quite specific in defining who is eligible for this specialized service. The applicant must have an actual physical or cognitive limitation which prevents use of our public transportation service. The diagnosis of a potentially limiting illness or condition is not sufficient to document the need for ADA Paratransit service.
  
- III. Determination of paratransit eligibility is not based solely on the information in this application. In addition, the Applicant may be required to participate in our Functional Assessment and Travel Training programs.
  
- IV. Incomplete or illegible applications will be returned for completion, which may delay the Applicant=s eligibility determination. The determination of eligibility will be made within 21 days from receipt of the completed application.
  
- V. Information provided by the Applicant may be shared with our Functional Assessment Team. Please read the Notice of Privacy Practices contained in this application packet.

**WHEN COMPLETED, PLEASE RETURN THIS FORM TO:**

Polk County Transit Services  
Drawer HS09, P.O. Box 9005  
Bartow, Florida 33831-9005  
Attention: **Polk Access Van**

SECTION A APPLICANT

FAX: (863)534-0421

Part 1

Lakeland Area Mass Transit District provides paratransit services in specially equipped vans to persons who cannot use the regular bus system. To be eligible for this service, individuals must have disabilities that prevent the use or access of regular bus system. Age of the rider is not by itself an eligible disability.

Eligible persons must be unable to use or access the regular fixed route system. Please complete Section A of this form. Section B must be completed by a health care professional. Any false or misleading statements will be cause for revoking Access Van eligibility.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt./Bldg. Number \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Emergency Contact Address: \_\_\_\_\_ Apt./Bldg. Number \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Part 2

Please check which condition(s) prevent you from accessing a regular bus:

None (Do not complete Section B, return Section A only.)

Distance to the bus stop. How far is the nearest bus stop? \_\_\_\_\_

Disability prevents the use of the fixed route bus system.

What is the disability that prevents you from using or accessing the wheelchair accessible fixed route bus? \_\_\_\_\_

How does this disability prevent the use or access of our fixed route bus?  
\_\_\_\_\_

Are there any effects of your disability of which we need to be aware? Please give specific answers that will assist us in making our determination.  
\_\_\_\_\_

### Part 3 Mobility Limitations

#### Can you:

- |  |  |  |  |
|--|--|--|--|
| Board a lift-equipped bus?               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Understand directions?                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Board a bus without a lift?              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Travel 200 ft. w/o assistance?                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Travel to the nearest bus stop?          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Travel 3/4 mile w/o assistance?                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Identify the correct bus?                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Balance while seated?                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Handle coins and/or tickets?             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Grip handles and railings?                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Climb a 12-inch step without assistance? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Can wait outside without support for 10 minutes? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you answered no to any of the above, why not? \_\_\_\_\_

### Part 4 Access Limitations

Can use lift-equipped bus, but cannot ride because:

- Lift cannot be operated where I board.
- Wheelchair/scooter cannot be placed on vehicle.
- Unable to use lift-equipped buses because \_\_\_\_\_

Can get to and from a regular bus stop only if:

- |  |  |
|--|--|
| <input type="checkbox"/> There are curb cuts               | <input type="checkbox"/> It is daytime               |
| <input type="checkbox"/> There is a sidewalk               | <input type="checkbox"/> No high levels of pollution |
| <input type="checkbox"/> Ground level or slightly inclined | <input type="checkbox"/> Receive travel training     |
| <input type="checkbox"/> No extreme weather                | <input type="checkbox"/> Other _____                 |

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

SECTION A APPLICANT

Part 5

Client Mobility (Please check all that apply)

- Need Assistance Walking  Hearing Impaired  Scooter
- Attendant Needed  Mentally Impaired  Guide Dog/White Cane
- No Bus Available  Need Escort  Sight Impaired
- Blind  No Special Needs  Stretcher
- Cancer Treatment  No Taxi  Walker
- Use Cane  Nursing Home Patient  Wheelchair, Can Transfer
- Car Seat  Portable Oxygen  Wheelchair, Cannot Transfer
- Too Far to Bus Stop  Renal Patient  Wide Wheelchair

Do you need someone to travel with you? Never Sometimes Always

Part 6 Person Completing Application

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_  
 Street Address: \_\_\_\_\_ Apt./Bldg. Number \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Daytime Phone: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_  
 Relationship to Applicant: \_\_\_\_\_

Part 7 Acknowledgment of Receipt of Notice of Privacy Practices

*I received a copy of Polk County's Notice of a Privacy Practices. I understand that if Polk County uses my personal health information in a manner that is different than described by the Notice, Polk County must first get my permission in writing.*

I am accepting this Notice on behalf of:

- Myself
- Another person as his/ her personal representative (parent, guardian, family member etc.)

\_\_\_\_\_  
 Signature of Patient or Personal Representative Date

**SECTION B HEALTH CARE PROFESSIONAL**

**Part 1 Professional Verification**

As a Health Care Professional familiar with the Applicant=s medical history, please complete this form documenting all conditions which prevent the use or access of fixed route bus service. Please assist us in certifying only those individuals, who because of disability, are truly unable to used regular bus service. (Please check all that apply.)

**Applicant=s Name:** \_\_\_\_\_

- Applicant cannot travel to or from a bus stop.       Applicant needs assistance to ride bus.
- Applicant unable to ride an accessible bus.

**Part 2**

- I have read the entirety of Section A prepared by the Applicant.  Yes    No
- I agree with all the information in Section A.  Yes    No
- Is the Applicant disabled?  Yes    No
- Does this disability prevent use or access of regular bus service?  Yes    No
- Can the Applicant wait outside in good weather?  Yes    No

**Part 3**

Capacity in which you are familiar with the Applicant:

Medical Diagnosis: \_\_\_\_\_ In your own words, what prevents the patient from  
independently      traveling      using      regular      or      accessible      buses?

**Mobility Limitations:**

- Applicant can travel 200 feet without assistance?  Yes    No
- Applicant can travel 1/4 mile without assistance?  Yes    No
- Applicant can travel 3/4 mile without assistance?  Yes    No
- Applicant can climb 12-inch step without assistance?  Yes    No
- Applicant can wait outside without support for 10 minutes?  Yes    No
- Applicant can safely navigate obstacles in travel to bus stop?  Yes    No

**SECTION B HEALTH CARE PROFESSIONAL**

**Cognitive Limitations:**

- Applicant can give address and phone number?  Yes  No
  - Applicant can recognize a destination or landmark?  Yes  No
  - Applicant can deal with unexpected situations?  Yes  No
  - Applicant can ask for, understand, and follow directions?  Yes  No
  - Applicant can safely travel through crowded/complex facilities?  Yes  No
  - Are there any other effects of this disability that we should be aware of?  Yes  No
- If yes to any of the above, please explain. \_\_\_\_\_
- 

**Part 4**

**Please print name and title of Health Care Professional:** \_\_\_\_\_

**Please indicate type of profession:**

- |                                  |                          |                  |                          |
|----------------------------------|--------------------------|------------------|--------------------------|
| Physician                        | <input type="checkbox"/> | Psychologist     | <input type="checkbox"/> |
| Occupational Therapist           | <input type="checkbox"/> | Registered Nurse | <input type="checkbox"/> |
| Licensed Mental Health Counselor | <input type="checkbox"/> | Ophthalmologist  | <input type="checkbox"/> |
| Licensed Clinical Social Worker  | <input type="checkbox"/> | Audiologist      | <input type="checkbox"/> |
| Independent Living Specialist    | <input type="checkbox"/> | Other _____      | <input type="checkbox"/> |

**License Number:** \_\_\_\_\_ **State Issued:** \_\_\_\_\_

**Agency (if any) of Health Care Professional:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_ **Apt./Bldg. Number** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone:** (\_\_\_\_) \_\_\_\_\_ **Ext:** \_\_\_\_\_

**Signature of Health Care Professional:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Notice to Health Care Professional concerning HIPAA:** Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Polk County Transit Services is a Covered Entity. Information provided by the Health Care Professional in this application is for the purpose of determining eligibility of the Applicant. Any protected health information provided by the Health Care Professional will be given the protection required by HIPAA and in accordance with the Polk County Board of County Commissioners Notice of Privacy Practices. The Notice of Privacy Practices is posted on the website at [www.polk-county.net](http://www.polk-county.net).