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

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**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 ¼ 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 ____________________________________________________________

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