



GADSDEN COUNTY

Transportation Disadvantaged Application

Section I: General Information

Full Name: _____
Last First M.I.

Address: _____
Street Address Apartment/Lot #

City State ZIP Code

Check one: House Apartment Mobile home Nursing home
 Group home

Is this address within the city limits? Check one: Yes No
For what type of travel do you intend to use this service? _____

How often do you plan to travel? Daily Weekly Monthly

Mailing Address: _____
Street Address Apartment/Lot #

City State ZIP Code

Home Phone#: _____ Alternate Phone#: _____

Email: _____

SSN#: _____

Gender: _____ Birth Date : _____

Emergency Contact Name: _____

Relationship: _____ Emergency Contact Phone#: _____

Section II: Mobility & Functionality Status

Check all Mobility Aids and/or Impairments that apply:

- Wheel Chair Walker Cane Crutches Leg Brace
 Portable Oxygen Totally Blind Legally Blind Deaf
 Hearing Impaired Mentally Impaired Speech Impairment

If you checked "Mentally Impaired", please indicate the type of mental disability:

I require an escort to travel. (Check one) Yes No

In case of mental or physical impairment, please answer the following questions:

1. Are you unable to drive yourself due to your disability? Yes No
If "yes", explain why. _____

2. How do you currently travel to your destinations? _____
3. Are you able to grip handles or railings? Yes No
4. Are you able to understand and follow directions/requests? Yes No
(IF NO, A PERSONAL ESCORT IS REQUIRED WHEN TRAVELLING.)
5. Can you deal with unexpected situations or changes in routine? Yes
 No (IF NO, A PERSONAL ESCORT IS REQUIRED WHEN TRAVELLING.)

Section III: Income Status

1. Are you currently receiving Medicaid? Yes No
If yes, include Medicaid#: _____
2. Check current assistance: Food Assistance (EBT) AFDC SSI
(Must attach most current supporting documentation if applicable.)
3. How many individuals live in your household? _____

4. What is your total annual household income? _____
 (Must attach most current supporting documentation, i.e. W2, check stubs, etc.)
5. Do you or does anyone in your household have a car? Yes No
- 5a. If "yes": **Owner's name** _____ **Tag #** _____
Year _____ **Make** _____ **Model** _____
- 5b. If "yes", is this vehicle available to you Sometimes Always Never?
6. Do you have friends or relatives who can transport you? Yes No
- 6a. If "yes" are they able to transport you Sometimes Always Never?

Would you be interested in a bus pass for travel on the **Gadsden Connector**, **Gadsden Express** and the **Quincy Shuttle**? Yes No

Section IV: Applicant Release

Applicant acknowledges that the information provided is true and correct to the best of their ability and will only be used to assess eligibility. *I hereby authorize my medical representative to release information regarding my level of functionality and need for transportation with BBT.* Any false information submitted will be found cause for immediate disqualification or revocation of eligibility.

Applicant Signature *Date*

If you are signing on the applicant's behalf, please indicate relationship to applicant (i.e. legal guardian, parent, personal care attendant, etc.)

Signature *Date*

Section V:

If you have indicated that you are mentally or physically impaired, please have a Medical Professional (such as a licensed physician, nurse practitioner, physical therapist, social worker, etc.) review this application and complete the following—

1. Do the disabilities of the applicant require that he/she bring a personal care attendant or escort when travelling? (Check one) Yes No (If "yes" the applicant **must** travel with an escort for **each** trip.)
2. Indicate which type of transportation is required by the applicant based upon his/her functionality. (Check one) Ambulatory Vehicle or Wheelchair & Walker accessible Vehicle

Please initial the following:

___ I hereby certify that I have treated the above mentioned applicant and I am familiar with his/her disability and health condition.

___ I hereby certify that I have read and agree with the information submitted in this application.

Please attach pertinent medical documentation (such as evaluations, test results, or reports) that would explain the diagnosis or limitations of the applicant. Failure to do so will delay eligibility determination.

I understand that by signing, I am acknowledging that the information in this evaluation is true and correct to the best of my knowledge. I certify that providing false or misleading information could result in the re-examination of eligibility status of the applicant and may be reported to the license/certification jurisdiction of the State of Florida.

Print or type name of medical professional *License Number*

Office Address: _____
Street Address *Building/Suite #*

City *State* *ZIP Code*

Office Phone#: _____ Extension: _____

Signature *Date*

****IF ANY SECTION IS LEFT BLANK, OR ANY REQUIRED DOCUMENTATION IS NOT SUBMITTED, THIS FORM **WILL** BE RETURNED AND ELIGIBILITY CONSIDERATION WILL BE DELAYED****

Return this application along with supporting documentation to the following address:

Big Bend Transit, Inc.
PO Box 1721
Tallahassee, FL 32302

Visit our website www.bigbendtransit.org for more information about the services that Big Bend Transit, Inc. offers in your community.

Office Use Only:

Received Date: _____ Approved Date: _____ Denied Date: _____