



# TAYLOR 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:

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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. \_\_\_\_\_

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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 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 **Perry Shuttle** bus pass for travel?

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](http://www.bigbendtransit.org) for more information about the services that Big Bend Transit, Inc. offers in your community.

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**Office Use Only:**

Received Date: \_\_\_\_\_ Approved Date: \_\_\_\_\_ Denied Date: \_\_\_\_\_