BIG BEND TRANSIT

MADISON 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 : _____
(Attach copy of state ID or driver's license)

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 ☐ Service Animal

☐ 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 climb stairs? ☐ Yes ☐ No
5. Are you able to understand and follow directions/requests? Yes ☐ No
   (IF NO, A PERSONAL ESCORT IS REQUIRED WHEN TRAVELLING.)
6. 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, 3-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 **Madison 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 for more information about the services that Big Bend Transit, Inc. offers in your community.

****

Office Use Only:

Received Date:_____Approved Date:_____Denied Date:_____