

## Transportation Disadvantage (TD)

## Shared-Ride

**Application Packet**

### Volusia County Public Transit

### Eligibility

Transportation Disadvantaged is defined as those persons who because of physical or mental disability, income status, or age are unable to transport themselves or purchase transportation and are, therefore, dependent on others to obtain access to health care, employment, education, shopping, social activities, or other life-sustaining activities or children who are handicapped or high-risk or at-risk as defined in s. 411.202, Florida Statutes.”

INCOME VERIFICATION

* Total Individual Monthly Income $ \_\_\_\_\_\_\_\_\_\_\_\_
* Please attach proof of your total income before tax including wages, tips, any Social Security income, pension, and other income. Acceptable forms of income verification include any of the following:
* Minimum of 2 most recent pay stubs
* DCF Cash Benefits/Child Support Letter
* Unemployment Compensation Income Verification
* Social Security Proof of Income letter (SSA / SSI / SSDI)
* Retirement/Pension statement (including VA)
* First page of you most recent tax return
* Other (specify)
* \*A Self-Declaration will not be accepted as proof of lack of income. If you have $0.00 income, and you live in a house or apartment, please indicate how your rent/utilities are paid (this includes balance remaining after rent subsidy)
* Additional documentation may be required to support individual income.

**Steps in the Eligibility Process**

1. Request/receive an Application Packet
2. Read the Eligibility Guide
3. Complete ALL questions on the TD Application
4. Submit your Professional Verification Form if required to do so. This form should be completely filled out and signed by one of the professionals listed on the form.
5. Send in your application via mail or fax:

* **Mail:** Votran

1. g Tree Road, South Daytona FL, 32119

* **Fax:** (386) 322-5119

Your eligibility will be determined within 21 days from the date your **COMPLETE**

application is received by the Votran Office.

##### EVERY QUESTION MUST BE ANSWERED.

**AN INCOMPLETE APPLICATION WILL BE RETURNED AND WILL DELAY**

**PROCESSING. *All applications are confidential.***

### Application for TD Eligibility Certification

*This application must be filled out entirely in order to be processed.*

**

New Applicant

#### Applicant Information

Recertification

Name: Birth Date: / / Residential

Street Address: Apt#:

City: State: Zip:

Mailing Address if different from above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Email:

**Emergency Contact Person Information**

Name: Relationship:

Phone (daytime): Phone (evening):

If this application has been completed by someone other than the Applicant, please complete the following:

Name: Phone Number:

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following questions are to help us determine your eligibility.

1. What is your current mode of transportation? Please check all that apply to you.

\_\_\_\_Walk/Ride Mobility Device \_\_\_\_ Bicycle

\_\_\_\_ Drive a vehicle \_\_\_\_ Ride in someone’s vehicle

\_\_\_\_ Taxi/Rideshare \_\_\_\_ Other

1. Are you able to use the Votran Fixed Route System now? \_\_\_\_Yes \_\_\_\_ No
2. Could you use the bus system if you could get to a stop? \_\_\_\_Yes \_\_\_\_ No

If no, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Based on where you live, where is the closest bus stop available to you? (To view the bus stops on the Route please visit our website at ([www.votran.org](http://www.votran.org))

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. In other places you may have lived, did you use their public bus, trolley, or train system?

\_\_\_\_ Yes \_\_\_\_ No

If yes, how long ago and how frequently did/do you use that system?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Please explain why you currently can or cannot use the Votran Fixed Route system.

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1. Is your condition: \_\_\_\_ Temporary \_\_\_\_ Permanent
2. When did your condition begin?

\_\_\_\_0-1 year ago \_\_\_\_ 1-5 years ago

\_\_\_\_ longer than 5 years \_\_\_\_ Birth

1. Does your condition require use of the following (please select all that apply)

\_\_\_\_Support Cane \_\_\_\_ Wheelchair (manual)

\_\_\_\_ White Cane \_\_\_\_ Wheelchair (reclining)

\_\_\_\_ Walker (collapsible) \_\_\_\_ Power Chair

\_\_\_\_ Walker (with seat) \_\_\_\_ Scooter

\_\_\_\_Crutches \_\_\_\_ Leg Brace(s)

\_\_\_\_ Prosthesis \_\_\_\_ Charcot Boot

\_\_\_\_ Leg Brace(s) \_\_\_\_ Hearing Aide(s)

\_\_\_\_ Portable Oxygen Device \_\_\_\_ Other Device

Please describe “Other Device” if selected: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does your condition require you to travel with portable medical equipment?

\_\_\_\_ Yes \_\_\_\_ No

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Are you able to walk with a mobility device?

\_\_\_\_ Yes \_\_\_\_ No

1. Please indicate which of the following you are able to do on your own or with the help of a mobility device (please check all that apply)

\_\_\_\_ Get in and out of a vehicle

\_\_\_\_ Get on or off a vehicle

\_\_\_\_ Understand bus schedules

\_\_\_\_ Grasp handles to get on or off a vehicle using steps, ramp or a lift

\_\_\_\_ Step up and down on a curb

\_\_\_\_ Get up or down 3 or 4 stairs

1. How far can you go on level ground with the use of your mobility aide, if you use any?

\_\_\_\_1-2 blocks \_\_\_\_ 3 or more blocks

\_\_\_\_ Less than 1 block \_\_\_\_ Unknown

1. Can you climb and descend steps on a Fixed Route Bus?

\_\_\_\_ Yes \_\_\_\_ No

1. Please tell us about any barriers that may prevent you from using Votran and whether those barriers are temporary or permanent. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Functional abilities using the Fixed Route Buses (check all that apply)

\_\_\_\_ I can get to and from a bus stop if the distance is not too far.

\_\_\_\_ My ability to use the Fixed Route Bus System can change from day to day.

\_\_\_\_ I can get to and from bus stops only if there are curb ramps and level

sidewalks.

\_\_\_\_ I have difficulty understanding or remembering all the things to use a Fixed

Route Bus System.

\_\_\_\_I have difficulty recalling information needed to travel alone.

1. Does your condition require you to travel with a Service Animal? (Emotional support or comfort animals are not considered service animals under the TD.)

\_\_\_\_Yes \_\_\_\_ No \_\_\_\_ Sometimes

1. If sometimes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What is your service animal trained to do for you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Does your condition require you to travel with a Personal Care Attendant (PCA)?

\_\_\_\_Yes \_\_\_\_ No \_\_\_\_ Sometimes

If yes or sometimes, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If your condition prevents you from using the Votran Fixed Route Bus System, can it be verified in writing by a Healthcare Professional (see verification form for list of approved persons who can fill it out)

\_\_\_\_ Yes \_\_\_\_ No

**Certification of Applicant**

I,

(print name)

## certify that the information contained in this application is true and complete to the best of my knowledge. The purpose of this application is to determine if I am eligible to use TD Services, or if at times I can ride the Votran Fixed Route Bus. I understand that any falsification of information on this form may lead to disqualification of eligibility.

Signature Date

# END OF APPLICATION

#### OFFICE USE ONLY

**Received Date: / / Status:**

**Approved Date: / / Denied Date: / /**

**Reviewed Date: / /**

**If denied reason:**

**To the Applicant:**

Please have this form completed by a professional before sending your application to Votran. Any one of the following professionals listed below may fill out and sign this Professional Verification form:

Authorization Release to Be Completed by the Applicant

I, authorize the professional completing the

(Printed Name of Applicant)

Professional Verification Form to release to Votran any protected health information about my disability/health condition in order to verify of my eligibility for TD service.

Signature: Date: \_\_\_\_\_\_\_\_\_\_

**To the Professional:** Please check your professional title

\_\_\_\_Physician \_\_\_\_ Physician Assistant

\_\_\_\_ Psychiatrist \_\_\_\_ Mobility Specialist

\_\_\_\_ Chiropractor \_\_\_\_ Registered Nurse

\_\_\_\_ Physical Therapist Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Greetings,

This is the Professional Verification Form for Votran Transit, Transportation Disadvantage Service (TD). The TD regulations state that persons are eligible for Paratransit service, if their pick-up and drop-off points are in the ¾ mile buffer zone and have a condition that prevents them from independently using Votran’s Fixed Route Bus Service. Paratransit eligibility is not based on the person’s lack of knowledge of the bus service, distance from bus service, ability to drive, language ability, or age. The information you provide will assist in determining under what circumstances this applicant may be eligible for Votran TD Paratransit Service.

1. Applicant’s Name:
2. Applicant’s DOB:
3. Capacity in which you know the applicant:
4. Last date of face-to-face contact with this applicant was on:
5. Please describe the condition that may prevent the applicant from independently using the Votran Fixed Route Bus system:
6. Would the condition prevent the applicant from using the Votran Fixed Route Bus Route some or all the time? Please Explain.
7. Is the applicant’s condition:

\_\_\_\_\_ Temporary

\_\_\_\_\_ Permanent

1. If temporary how long would you anticipate the condition lasting? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Does the applicant have the mental capacity, visual, and/or hearing ability to:

* + Ask for, understand, and follow directions? \_\_\_\_\_ Yes \_\_\_\_\_ No
  + Safely/Effectively transfer to another bus if needed? \_\_\_\_\_ Yes \_\_\_\_\_ No
  + Are there any other mobility concerns of which Votran should be aware? If so please explain:

#### Can the applicant complete the following on their own or with the aid of a mobility device?

* + Travel less than a block (approx. 200ft)? \_\_\_\_\_ Yes \_\_\_\_\_ No
  + Step up on to and off a curb? \_\_\_\_\_ Yes \_\_\_\_\_ No

* + Grip a hand rail? \_\_\_\_\_ Yes \_\_\_\_\_ No

1. Does the applicant use a mobility device(s)? Please check all that apply.

\_\_\_\_Support Cane \_\_\_\_ Wheelchair (manual)

\_\_\_\_ White Cane \_\_\_\_ Wheelchair (reclining)

\_\_\_\_ Walker (collapsible) \_\_\_\_ Power Chair

\_\_\_\_ Walker (with seat) \_\_\_\_ Scooter

\_\_\_\_Crutches \_\_\_\_ Leg Brace(s)

\_\_\_\_ Prosthesis \_\_\_\_ Charcot Boot

\_\_\_\_ Leg Brace(s) \_\_\_\_ Hearing Aide(s)

\_\_\_\_ Portable Oxygen Device \_\_\_\_ Other Device

Please describe “Other Device” if selected:

1. Does the applicant require a Personal Care Attendant (PCA) to travel? Please explain:
2. Are there any other comments you would like to include about the applicant in regard to their condition?

*I, certify under penalty of perjury that the information contained in this form is true and correct.*

Name: Position/Title:

Signature: Date: / /

Name of Organization/Office:

Address:

Phone: Email:

#### Instructions for Submitting This Form:

If the applicant requests you return this form to them, please return it to the applicant.in an official sealed envelope. You may also submit the form via the following methods:

**Mail: Attn: Eligibility Department**

Votran 950 Big Tree Road, South Daytona,

FL 32119

**Fax: Eligibility Department**

(386) 322-5119

CURRENT TRAVEL INFORMATION

How many personal vehicles are owned or used by members in your household?

0 1 2 3 or more

Are these available for use? Yes No

If you have a vehicle and driver in your household, you are not eligible for Votran Gold TD service. If the vehicle or driver is not available due to work, school, etc., the Commission for the Transportation Disadvantaged requires a vehicle/work schedule on company or school letterhead with your application or a notarized statement as to why the vehicle cannot be used to transport the applicant.

SECTION 6.

List three of your most frequent destinations and how you get there now.

1. Where do you go? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you get there now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Where do you go? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you get there now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Where do you go? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you get there now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have Medicaid Insurance? Yes No

Medicaid number if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have Medicaid Waiver for any trips? Yes No

Please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_