Americans with Disabilities Act (ADA) Paratransit Application

INSTRUCTIONS FOR COMPLETING THE ELIGIBILITY APPLICATION PROCESS

Thank you for your interest in the Americans with Disabilities Act (ADA) Paratransit program, a shared-ride door-to-door service provided to riders unable to use fixed route buses due to a qualifying disability.

- **Please provide all information, fill in all blanks, and sign where appropriate.**
- **The applicant must attach a photocopy of an official government ID card (license, passport, state issued ID, etc.) to this application.**
- **The Medical Verification Form must be completed and signed by a licensed professional familiar with the applicant's disability, health, and functional abilities.**
- **Incomplete applications will be returned to the applicant, delaying the approval process.**

Licensed professionals include Physicians, Physician's Assistants, Advanced Practice Registered Nurses, Physical and Occupational Therapists, Certified Rehabilitation Counselors, and Certified Orientation and Mobility Specialists. Disability verification by a licensed professional does not guarantee approval, but it does play a major role in the eligibility determination process.

GOPASCO may request more information or require the applicant to attend an in-person functional assessment at a designated facility. If required, the applicant will be instructed how to complete the assessment. If an applicant does not have transportation to the assessment, GOPASCO will provide it.

GOPASCO will determine eligibility within 21 calendar days of receiving a complete application. Eligibility results will be sent to the applicant by U.S. Mail. If GOPASCO cannot make a determination in 21 days, the applicant will be eligible for paratransit rides until the final determination is made.

Approved riders 14 years and older may travel alone. *Approved riders **13 years and younger** and all riders with special needs must travel with a Personal Care Attendant (PCA) who helps them ride safely*. GOPASCO does not provide a PCA and drivers are not qualified to act as a PCA. If the applicant needs a PCA, please indicate this on the application.

All information provided to GOPASCO is confidential and will not be shared with any other person or agency without the applicant's written consent. For additional information, call GOPASCO at **(727) 834-3322** or visit www.GoPasco.com. **Please drop-off or mail the completed application to:**

GOPASCO

8620 Galen Wilson Boulevard

Port Richey, FL 34668

To comply with HIPAA and privacy policies, GOPASCO does not accept faxed or emailed applications.

GoPasco ADA Paratransit Application

Applicant Information

Application Type: ☐New ☐Temporary ☐Recertification Client Number:_____

First Name:_____ MI:_____ Last Name: _____

Street Address:_____ Apartment:_____

Facility, Subdivision, or Community Name:_____

City:_____ State:_____ Zip Code:_____

Date of Birth:_____ Gender: ☐Male ☐Female ☐Other:_____

Phone:_____ Mobile Phone:_____ Email Address: _____

Pasco Residency: ☐Full Time ☐Part Time ☐Temporary ☐Non-Resident

Emergency Contact:_____ Relationship:_____ Phone:_____

Language Preference: ☐English ☐Spanish ☐Other: _____

Is applicant a United States veteran? ☐Yes ☐No

Veterans ride free on GoPasco ADA trips. To report veteran status, attach a copy of one of the following identification cards to this application: Military ID Card, DD Form 2, VA Card, or a State ID marked "V" (optional step).

Personal Care Attendants (PCA) ride free of charge with clients who have a medically justifiable need, but GoPasco does not provide a PCA. ,Does the applicant require a PCA?

☐Yes ☐No, If yes, why:

If someone assisted the applicant with this form, please provide

Name:_____ Relationship: _____ Phone: _____

This information is optional, used only for statistical reporting purposes; **it is not used to determine eligibility for services. Please check all that apply and fill in the blanks:*

☐*American Indian* ☐*Asian* ☐*Black* ☐*Hispanic* ☐*Pacific Island* ☐*White* ☐*Other:*_____

Marital Status:_____ Cultural Considerations:_____

Applicant Information, continued

What mobility aids or medical devices does the applicant use (check all that apply)?

☐ Oxygen ☐ Cane ☐ Leg Braces ☐ Walker ☐ Crutches ☐ Manual Wheelchair

☐ Power Wheelchair/Scooter ☐ Bariatric Wheelchair ☐ White Cane ☐ Cue Cards

☐ Service Animal ☐ Other: _____

If in a wheelchair, what is combined weight of client and wheelchair? _____

How does the applicant currently travel to work, school, appointments, and errands?

Can the applicant ride the bus if they were provided a bus pass? ☐ Yes ☐ No

Would the applicant like GoPasco to teach them how to ride a bus? ☐ Yes ☐ No

Can the applicant perform the below activities without help? Please answer Yes, No, or Not Sure.

Board a bus	_____	Handle money and passes	_____
Understand directions	_____	Travel on sidewalks	_____
Travel to nearest bus stop	_____	Stand at a bus stop	_____
Identify the correct bus	_____	Cross a street	_____
Balance while seated	_____	Grip handles or rails	_____
Recognize landmarks	_____	Wait outside for bus	_____

What medical conditions might prevent the applicant from riding a bus?

☐ Arteriosclerosis ☐ Asthma ☐ Cancer ☐ Cerebral Palsy ☐ COPD ☐ Cognitive Defect

☐ Congestive Heart Failure ☐ Epilepsy/ Seizures ☐ Heart Attack ☐ Hearing Impairment

☐ HIV/ AIDS ☐ Intellectual Disability ☐ Kidney Disease/ Dialysis ☐ Lupus ☐ Mental Illness

☐ Multiple Sclerosis ☐ Paraplegia ☐ Parkinson's Disease ☐ Peripheral Vascular Disease

☐ Quadriplegia ☐ Stroke/ Cerebral Trauma ☐ Thrombosis ☐ Visual Impairment

☐ Other: _____

Is there anything else GoPasco should know about the applicant to determine eligibility?

Applicant's Certification

Health Insurance Portability and Accountability Act (HIPAA) and Privacy Policy

GoPasco will safeguard and keep confidential all information about any applicant or client of any service offered by GoPasco. This applies to all written, verbal, electronic, or other communications between GoPasco and any applicant or client, which applies to both personal and medical information. GoPasco will only give employees access to this information when they need it to make an eligibility determination, provide paratransit service to the applicant, or when fulfilling regulatory reporting requirements. The applicant acknowledges that GoPasco will not share their personal and medical information with any person or agency without their express written consent. GoPasco may verify the information provided in this application with the licensed professional providing it. *By signing below, I acknowledge that I have read, understand, and received a copy of this notice.*

Applicant Signature: _____ Date: _____

Medical Information Release

By signing below, I give permission to my Healthcare Provider(s) to release my medically protected information to GoPasco, for the sole purpose of determining my eligibility to receive GoPasco paratransit services.

Applicant Signature: _____ Date: _____

Applicant Affidavit

I understand the purpose of this application is to help GoPasco determine if I cannot use the GoPasco fixed route bus service and must use paratransit services. I certify, to the best of my knowledge, that the information in this application is true and correct. I understand that providing false or misleading information or making false statements on behalf of others constitutes fraud, a felony under Florida law, which may result in a reevaluation or revocation of my eligibility.

Applicant Signature: _____ Date: _____

If the applicant is unable to sign, the applicant's power of attorney may sign for the applicant and must provide proof of their power of attorney.

A photocopy of the applicant's valid government photo ID must be attached to this application. Acceptable forms include a state issued driver's license or identification card, a U.S. military identification card, or a passport.

GoPasco ADA Paratransit Application

Medical Verification Form

This page must be completed and signed by the applicant's healthcare provider before submitting this entire packet to GoPasco for review.

Applicants Name:_____ Applicants Date of Birth: _____

Note to Healthcare Provider: This form must be completed by a licensed Physician, Physician's Assistant, Advanced Practice Registered Nurse, Physical Therapist, Occupational Therapist, Certified Rehabilitation Counselor, or Certified Orientation and Mobility Specialist.

By completing and signing this form the licensed professional certifies the information on the application to the best of their knowledge. The Americans with Disabilities Act of 1990 requires GoPasco to provide complementary paratransit service to those who are unable to use GoPasco's fixed route bus service due to a disability. This information helps GoPasco evaluate the applicant's ability to travel to and from a public bus stop and to ride a bus, without assistance. ***All GoPasco buses are ADA accessible, with positions to secure wheelchairs and other mobility devices.*** *The information that you provide must be based solely upon the applicant having a physical or mental impairment that substantially limits one or more major life activities.*

What disability or condition prevents the applicant from riding the fixed route bus?

Is the disability or condition Permanent? ☐ Yes ☐ No; if no, duration: _____

Check any of the following areas impacted by the applicant's disability or condition:

☐ Orientation ☐ Monitoring Time ☐ Gait or balance ☐ Problem solving ☐ Judgment

☐ Ability to travel alone ☐ Short-term memory ☐ Long-term memory ☐ Social Behavior ☐ Other:

If applicant takes prescribed medication, does it diminish their functional ability to travel alone?

☐ Yes ☐ No; if yes, explain: _____

By signing this form, I certify the medical information provided in this application is true and correct to the best of my professional knowledge.

Signature:_____ Profession:_____ Date: _____

Printed Name: _____ Phone: _____ License Number: _____