Escambia County Transportation Disadvantaged TD North Escambia Mobility Enhancement Grant (MEG) Demand Response Application Form

Escambia County Community Transportation (ECCT) is Escambia County's demand-response public transportation system operated with cooperative funding from the Florida Commission for the Transportation Disadvantaged (TD). "Transportation disadvantaged" means "those persons who because of physical or mental disability, income status, or age are unable to transport themselves or to purchase transportation and are, therefore, dependent upon others to obtain access to health care, employment, education, shopping, social activities, or other life-sustaining activities.

The Florida Commission for the Transportation Disadvantaged has awarded a Mobility Enhancement Grant (MEG) to Escambia County to begin February 20, 2019 to enhance transportation services to all residents of northern rural section of Escambia County.

ELIGIBILITY CRITERIA AND GUIDELINES

Origin and destination locations must be within the designated area of Northern Escambia County- Century, Molino, Walnut Hill, McDavid, Davisville, Bratt, and any other locations north of Quintette Road.

Eligibility Criteria - one or more of the following

- Persons with no other means of transportation that live within the designated area of Northern Escambia County. (required)
- Persons age 60 or older; or
- Persons with disabilities preventing use of ECAT bus routes. A recognized disability (temporary or permanent) verified by an accepted medical professional; or
- Persons that have an economic hardship. Gross annual household income does not exceed 125% of the Department of Health and Human Services poverty guidelines
- An application with proper documentation must be submitted.

- **Service Hours: Monday-Friday 6:00 AM to 7:00 PM**
- North Escambia MEG Transportation will also make connections at the Century Courthouse bus stop to the ECAT Route 60 Century Bus.
- North Escambia MEG clients may be asked to adjust their pick-up times for effective scheduling..
- Due to the availability of program funds, trips may be denied based on trip purpose.
- Call 850-595-0501 to schedule appointments Monday through Friday from 8:00 AM to 4:00 PM. Rides must be scheduled one working day in advance. North Escambia MEG rides are scheduled on a first come, first serve basis. North Escambia MEG clients can call at least 24-hours in advance to request a trip. Reservations for same day trips will be determined based on availability and a case-by-case basis.
- **The evaluation process normally takes up to maximum of three (3) business days from the receipt of the completed forms.**
- **North Escambia MEG Fare: $1.00 each way (per person).**

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INSTRUCTIONS FOR COMPLETING THIS APPLICATION

1. When completing the application, please type or PRINT legibly. Complete all sections of the application requested, return all information requested, and sign where indicated.
2. Illegible, incomplete and/or unsigned application will not be accepted for approval. This will cause a delay in your eligibility determination.
3. If you are applying and have a disability, the medical verification section is required and must be professional; or
4. If you are applying and DO NOT have a disability, the medical verification section is NOT required.
5. If you are applying based on income, proof of your income is required. Acceptable types of proof of income are listed in Part 4 - Household Income.
6. Completing this application does not automatically certify the applicant for paratransit services.
7. All applicants will be notified of the outcome of their application.

Please check one of the following:

☐ **If applying for North Escambia MEG Transportation based on age (60 or older) and unable to transport yourself or to purchase transportation:**

- Complete Parts 1, 2, 3, 5, and 6.
- Attach a copy of any photo identification card with date of birth.

☐ **If applying for North Escambia MEG Transportation due to disability or medical reasons and unable to transport yourself orto purchase transportation:**

- Complete Parts 1, 2, 3, 4, 5, 6, and 7.
- Read and sign Part 7 Applicant's Authorization, providing the applicant's authorized signature to release medical information.
- A currently Licensed Professional completes Part 8.

☐ **If applying for North Escambia MEG due to a total gross annual household income at or below 125% of the Federal Poverty Level and unable to transport yourself or to purchase transportation:**

- Complete Parts 1, 2, 3, 5, and 6.
- You MUST attach proof of income required for income verification. Please send copies, as proof of income will not be returned.

Acceptable forms of proof of income include current copies of:

- Minimum of (2) most recent pay stubs
- Retirement/Pension Statement (includes VA)
- First page of your tax return
- DCF Benefit Letter
- Social Security Income Verification (SSI or SSDI)
- Unemployment Compensation Income
- Other proof of income

Note: If no one in your household has income, you must attach proof of Food Stamp eligibility or a signed letter on agency letterhead verifying that you have no income.

PLEASE RETURN COMPLETED APPLICATION ALONG WITH
COPIES OF ELIGIBILITY QUALIFYING DOCUMENTS (Photo ID and Proof of Income) TO:
Escambia County Community Transportation
315 South A Street, Pensacola, FL 32502
850-595-0501 Office and 850-595-0502 Fax

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OFFICE USE ONLY

Application Received Date:____________

Application Complete? Yes________ No ________ New Applicant______ Current Client _______

Photo ID? Yes_________ Medical Verification**?** Yes________

Proof of Income? Yes_______ Gross Household Income: ______________________________

Eligible? Yes__________ *(If eligible, complete Approval Status/Review Date section below)*

Eligibility Pending? Yes_______ Reason Pending? ___________________________________

Denied? Yes______ Reason Denied: ________________________ DATE DENIED:____/___/_____

DATE (APPROVAL/ DENIAL) NOTIFICATION LETTER SENT: _____/______/ _______

APPROVAL STATUS AND REVIEW DATE :

REVIEWED BY: _______________________ PRINT NAME: _________________________

Review Date: ______/_______/ _____

PART 1: GENERAL INFORMATION

☐ **Check here if you are a current Paratransit rider**

Please check which program: ☐ **ADA** ☐ **Transportation Disadvantaged (TD)** ☐ **Both**

Name: *(Last Name, First Name, Middle Initial)*		Date:
Date of Birth:	Social Security #:	Sex: ☐ Male ☐ Female

Escambia County Community Transportation collects your Social Security number for the following purposes: identification, verification, as a unique identifier and for search purposes.

Ethnicity: (for statistics only, optional)

☐ White Non-Hispanic ☐ Black/African-American Non-Hispanic

☐ Hispanic ☐ Other (specify): _______________

Street Address:		Apartment/ Building #:
City:	State:	Zip Code:
Name of Subdivision, Building Complex Name, or additional information needed to find address:		

Is this a ☐ House ☐ Apartment/Duplex/Townhouse ☐ Assisted Living Facility/Nursing Home ☐ Other

Does the facility you live in have a vehicle to transport residents?☐ **YES** ☐ **NO**

Telephone # (Home):	Telephone # (Cell):
Email:	

Name_______________________________

Emergency Contact: Name and telephone number of someone we can call in an emergency.

Name:_______________________________ Phone:_______________

Relationship to Applicant: _______________________________

Do you require materials or correspondence in an alternative format? If so, please specify;

☐ Large Print ☐ Audio ☐ Computer ☐ Other please specify: _______________

PART 2: CURRENT TRAVEL INFORMATION

1. How do you currently travel to appointments or to other activities such as grocery shopping?

____

2. Have you ever used ECAT-Escambia County *Area Transit's* regular bus service? ☐ **YES** ☐ **NO**

3. Please indicate the reasons why you are seeking Paratransit eligibility: **(check all that apply)**

☐ I do not know how to use ECAT's regular bus service, but could use it if received training.

☐ I cannot use ECAT's regular bus service for all my trips due to the service area.

☐ I can never use ECAT's regular bus service because of my disability.
State reason:_______________________________

☐ Other reasons_______________________________

NOTE: All Escambia County *Area Transit's* buses are wheelchair accessible. Therefore, use of a wheelchair does not automatically justify use of Paratransit service.

4. Do you have access to a vehicle? ☐ YES ☐ NO
If YES, why are you unable to use the vehicle? ___________

5. What other means of transportation are available for you to use? _______________

6. Please list two (2) of your most frequent trips and how you get there now.

1. Destination: _______________________________
How do you get there now? ☐ Car ☐ Bus ☐ Van/Taxi ☐ Other ___________

2. Destination: _______________________________
How do you get there now? ☐ Car ☐ Bus ☐ Van/Taxi ☐ Other _________

PART 3: HOUSEHOLD INCOME

1. How many persons are in your household that reside at the address provided in Part 1?
(Household includes yourself, any relatives, caregivers, or others living at the same address)

____

2. How many vehicles are in your household? _______________________________

Name____________________________________

3. You MUST complete the table below for each immediate family member of your household (YOURSELF, spouse, parents, children, step and foster children, siblings, grandparents, grandchildren) living at the same address). For Monthly Gross Income, list all income by source and attach proof of income for each source as described below. Gross Income is before all taxes and withholding and includes pay, Social Security, Disability, Cash Benefits, and child support:

Name	Date of Birth	Relationship to You	Monthly Gross Income

4. Attach proof of each source of income listed above for you and all members of your household to this completed application. Proof of Income is required for income verification. Please provide copies as proof of income will not be returned.

Acceptable forms of proof of income include current copies of:

- Minimum of (2) most recent pay stubs
- DCF Cash Benefit/Child Support Letter*
- Retirement/Pension Statement (includes VA)
- 1st page of your tax return
- Unemployment Compensation Income Verification
- Food Stamp Eligibility
- Social Security Income Verification or Proof of Income Letter (includes SSI and SSDI)

If no one in your household has income, you must submit proof of Food Stamp eligibility or a signed letter on agency letterhead verifying that you have no income. Applications missing proof of income/no income will not be approved for TD MEG Funding until this information is received.

PART 4: INFORMATION ABOUT THE APPLICANT'S DISABILITY

1. What type or types of disabilities do you have?

☐ Physical Disability ☐ Visual Impairment/Blindness ☐ Developmental Disability
☐ Mental Illness ☐ Other ☐ None

Please describe your disability in more detail:____

2. Is the disability temporary or permanent?

☐ TEMPORARY DISABILITY. I expect it to last for another______months.
☐ PERMANENT DISABILITY.
☐ I don't know.

Name____

3. **Do you use a service animal? If yes, please describe the type of animal.**
   ☐ YES → Type of animal: ________________________________
   ☐ NO

4. **Do you travel with a Personal Care Attendant (PCA) who assists you with daily life functions? (Someone you need all or some of the time to assist you. A companion or guest is not considered a PCA).**
   ☐ YES, always →
   ☐ YES, sometimes →
   ☐ NO

   I need assistance with (check all that apply):
   ☐ **Mobility** ☐ **Reading**

PART 5: QUESTIONS ABOUT APPLICANT'S MOBILITY

1. **Please check below if you use any of the following mobility aids or equipment and answer the additional questions that apply to your type of aid or equipment.**

   ☐ Cane ☐ Walker ☐ Manual Wheelchair ☐ Power Wheelchair ☐ Power Scooter/Cart

   ☐ Oxygen CO2 ☐ Other:____________________ ☐ I do not use aids or equipment.

2. **If you use a mobility aid, please indicate below the size and weight:**
   - Is your wheelchair/scooter/cart more than 48" long? ☐ YES ☐ NO
   - Is your wheelchair/scooter/cart more than 30" wide? ☐ YES ☐ NO
   - Is your weight plus the weight of your wheelchair/scooter/cart more than 600 pounds? ☐ YES ☐ NO

***NOTE: Escambia County Community Transportation *may not be able to accommodate you if your wheelchair, scooter, or cart is longer than 48 inches or wider than 30 inches or if your total weight with your wheelchair is more than 600 pounds.*

3. Please answer the following questions.
   A. Can you travel without assistance the distance of:
      200 feet ☐ YES ☐ NO ¼ mile ☐ YES ☐ NO ¾ mile ☐ YES ☐ NO
   B. Can you climb a twelve-inch step with assistance? ☐ YES ☐ NO
      Without assistance? ☐ YES ☐ NO
   C. Can you wait outside without support for ten (10) minutes? ☐ YES ☐ NO
   D. Can you give an address and telephone number upon request? ☐ YES ☐ NO
   E. Can you recognize a destination or landmark? ☐ YES ☐ NO
   F. Can you ask for, understand and follow directions? ☐ YES ☐ NO
   G. Can you handle unexpected situations or changes to your routine? ☐ YES ☐ NO

4. **Can you get on and off a bus that has a lift?**
   ☐ YES (Answer 4A Box) →
   ☐ NO (Answer 4A Box) →
   ☐ SOMETIMES
   ☐ I don't know because I have never tried

4A. Please check all that apply:
☐ My mobility aid will not fit on the lift
☐ I cannot steady myself when the lift is moving
☐ I do not feel secure on the lift
☐ Other: ________________

Name____

5. **Once inside a bus, can you get to a seat or wheelchair position by yourself?**

- ☐ YES
- ☐ NO (Answer 5A Box) ➡
- ☐ SOMETIMES (Answer 5A Box) ➡
- ☐ I don't know because I have never tried

5A. Please check all that apply:

- ☐ I need someone to help me
- ☐ I have a balance problem
- ☐ I need the seat nearest the door
- ☐ I have trouble finding a seat
- ☐ I cannot hold onto the handrails
- ☐ Other: ____________________

PART 6: APPLICANT'S CERTIFICATION (Applicant must sign)

I understand the purpose of this application form is to determine if I am eligible for Transportation Disadvantaged. I understand that the information about my disability and income contained in this application will be kept confidential and shared only with professionals involved in evaluating my eligibility. In signing, I acknowledge that, to the best of my knowledge, the information in this application form is true and correct. I understand that providing false or misleading information could result in the re- examination of the eligibility status as well as other actions by Escambia County Community Transportation.

______________________________________ ____________________

(Applicant's Signature) **(Date)**

If Applicant is unable to sign this form, he/she may have someone sign and certify on applicant's behalf.

Proxy Signing for Applicant:_	Date:
Print Name:	Relationship:

If someone assisted you in completing this form and you would like them to also be informed of decisions regarding your eligibility, please provide us with that person's name, address, and phone number below:

Name:____________________________________Relationship: __________________

Address: ____

City:_________________________State:____________ Zip Code: _______

Telephone: _____________________________

Can they assist with your travel arrangements in the future? ☐ **YES** ☐ **NO**

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Escambia County Community Transportation
315 South A Street, Pensacola, FL 32502
850-595-0501 Office and 850-595-0502 Fax

Name____

Part 7: APPLICANT'S AUTHORIZATION (Applicant must sign)

I hereby authorize the following named professional to provide information about my disability and abilities to Escambia County Community Transportation and/or persons assisting Escambia County Community Transportation to determine my eligibility for North Escambia MEG Transportation. I understand that this information will be used solely for determining my eligibility for North Escambia MEG Transportation and that all medical information about my disability will be kept confidential.

Applicant's Signature:________________________________ Date: ____________________

If Applicant is unable to sign this form, he/she may have someone sign and certify on applicant's behalf.

Proxy Signing for Applicant:	Date:
Print Name:	Relationship:

Part 8: MEDICAL VERIFICATION - *(MUST BE COMPLETED BY MEDICAL PROFESSIONAL*

APPLICANT'S NAME:____Date of Birth:____/____/_____

(Must be completed by accepted medical professional)

NOTE: This part must be completed and signed by a licensed medical professional before returning the application to our office. Accepted medical professionals include:

- Physician/Doctor (M.D. or D.O. or D.C.)
- Doctor of Osteopathic Medicine
- Doctor of Chiropractic
- Occupational Therapist- Licensed/Registered
- Audiologist
- Ophthalmologist
- Psychologist/Psychiatrist
- Clinical Social Worker
- Registered Nurse
- Physical Therapist
- Licensed Practical Nurse
- Rehabilitation Specialist

1. Has this person been diagnosed with a cognitive, mental, physical, or other disability preventing use of the ECAT public transportation bus service? ☐ YES ☐ NO

   If yes, please list and explain how the disability/disabilities prevent the applicant from using the ECAT public transportation bus service: ____

   ____

   ____

2. ☐ YES ☐ NO Does this person require a Personal Care Attendant (PCA) while traveling?

3. How long has this disability been present? ____

   Is the disability ☐ **permanent or** ☐ **temporary**?

   If temporary, how long? __________

*Name*___________________________________

4. Please describe any other medical conditions this person has currently and severity, in detail, including any restrictions, limitation, and prognosis____

____

____

____

5. How long have these conditions been present? ________________________________

   Is condition ☐ **permanent or** ☐ **temporary**?

6. Is this person able to:
   - ☐ YES ☐ NO Communicate addresses, destinations, and phone numbers?
   - ☐ YES ☐ NO Read and/or monitor time?
   - ☐ YES ☐ NO Ask for, understand, and follow instructions?
   - ☐ YES ☐ NO Deal with unexpected situations or changes in routine?
   - ☐ YES ☐ NO Safely and effectively travel through crowded or complex facilities?

In signing, I acknowledge that, to the best of my knowledge, the information in this evaluation form is true and correct. I understand that providing false or misleading information could result in the re- examination of the eligibility status of the applicant as well as prosecution to the maximum extent allowed by the laws of the state of Florida.

Signature:____Date:____________________

Print or type Name and Title: ____

State of Florida License Number: ____

Business Address:____________________________________Phone Number: ___________

City:____________________________________State:_________Zip Code: ____________

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