TRANSPORTATION DISADVANTAGED (TD) DOOR-TO-DOOR PROGRAM

Dear TOPS! Applicant:

Thank you for your interest in TOPS! The Florida Commission for Transportation Disadvantaged program is one of the transportation programs provided by TOPS!

Door-to-Door Paratransit Transportation – Shared-ride paratransit transportation is provided to qualifying individuals who are prohibited from using Broward County Transit (BCT) fixed-route bus service due to financial, physical and/or mental restrictions or children who are handicapped, high-risk or at-risk. Door-to-door paratransit transportation is provided to health care, employment, education, shopping, social activities and other life-sustaining activities.

Transportation is mileage or facility restricted based on trip purpose

Dialysis – Choice of facility within five miles of residence
Radiation/Chemotherapy – Choice of facility within ten miles of residence
All other trips – Closest to residence providing service (i.e. grocery, pharmacy, VA clinic, shopping center)

ELIGIBILITY: TD services require applicant to qualify under current Federal Poverty Level Guideline, depending on number of family members in household, at the 225 percent level.

Complete Sections 1 and 2. Section 3 must be completed and signed by a Florida licensed physician (submit all three sections together).

Completed TD application must contain all requested information, be legible and have all required identification and applicable financial supporting documents included when submitted. Incomplete applications will be returned.

Complete application information prior to printing

Application/supporting document(s) cannot be submitted via fax or e-mail

NOTICE OF COLLECTING SOCIAL SECURITY NUMBER (SSN) FOR GOVERNMENT PURPOSE
Broward County collects SSNs for different purposes. The Florida Public Records Law, Section 119.071(5), F.S. (2007) requires the County to give you this written statement explaining the purpose and authority for collecting your SSN.

FORM	PURPOSE	AUTHORIZATION
TD Application	Conduct eligibility verification and monitor for system abuse	County policy (See Note)

NOTE: Broward County collects your SSN in the performance of a duty or responsibility the County must complete in accordance with law or business necessity. In the event a law does not specifically provide the County with the authority to collect your SSN, it is imperative the County collect your SSN and this is expressly provided in section 119.081 (5) 2.b.

Transportation Disadvantaged Application
DOOR-TO-DOOR PARATRANSIT SERVICE
Broward County Transit

Office use only
PIN # _____
Date Approved_____
Date Denied _____

INSTRUCTIONS:
Complete Sections 1 and 2. Section 3 must be completed and signed by a Florida licensed physician (submit all three sections together and attach required documents).

COPY OF CURRENT / VALID FLORIDA DRIVER'S LICENSE OR FLORIDA ID IS REQUIRED WITH APPLICATION

(ID MUST INDICATE BROWARD COUNTY ADDRESS)

SECTION 1 – GENERAL INFORMATION (PLEASE PRINT)

Name of Applicant:	Phone:
Home Address:	
Mailing Address (if different):	
Is a vehicle registered in your name? YES ☐ NO ☐ Do you drive? YES ☐ NO ☐	
Date of Birth:	Social Security Number:
Are you receiving Medicaid? YES ☐ NO ☐	If YES, Medicaid #:
Emergency Contact:	Phone:
Number of ***relatives***, including self, living in household:	Total Annual Household Income (**Must total lines 1 through 8 below**):

Indicate amount of annual income/benefit received by, or indicated on, each of the following sources for ALL family members of household (list household family members on reverse side):

1. Page #1 of individual tax return or most recent pay stub - - - - - - - - - $_____
2. DCF Benefit Letter / Cash Assistance / SNAP / Food Stamps - - - - - - $_____
3. Unemployment Compensation Income Verification - - - - - - - - - - - - $_____
4. Social Security Income Statement or Proof of Income Letter (SSI / SSDI) - $_____
5. Retirement / Pension / Investment Statement - - - - - - - - - - - - - - - $_____
6. Disabled Veteran's Benefit Letter - $_____
7. Housing benefits (HUD, Section 8) - $_____
8. Other (Specify) - $_____

If $0 income – Submit signed letter, on agency letterhead, from social service agency verifying $0 income.

If $0 income, and you live in a house or apartment, indicate how rent / utilities are paid (this includes balance remaining after rent subsidy).

CURRENT COPY OF OFFICAL DOCUMENT(S) FOR EACH ITEM(S) COMPLETED ABOVE (#1 THROUGH #8) MUST BE SUBMITTED WITH APPLICATION OR APPLICATION WILL NOT BE PROCESSED

(OVER)

SECTION 1 – GENERAL INFORMATION (CONTINUED) (PLEASE PRINT)

VETERAN'S INFORMATION Are you a United States veteran? YES ____ NO ____

If YES, type of Military Discharge:

*Honorable ____ *General (Honorable Conditions) ____

* Honorable and General (Honorable Conditions) discharge eligible for 50% fare to/from VA clinics.

If YES, attach copy of Discharge

Need a copy of your Discharge? Contact Broward County Elderly and Veterans Services, 954-357-6622

SECTION 2 – HOUSEHOLD MEMBERS (RELATIVES)

NAME	DATE OF BIRTH	RELATIONSHIP	SOCIAL SECURITY NUMBER

I attest all information is correct and any changes will be reported to Paratransit Services immediately.
(Original signature only – DO NOT E-MAIL OR FAX)

_____ _____
Signature of Applicant Date

_____ _____
Signature of Preparer (if other than applicant) Date

_____ _____
Print Name (Preparer) Relationship

Return to: Broward County Transit - Paratransit Services Eligibility
1 N. University Dr. - 3100-A, Plantation, FL 33324
(Application may be mailed/hand delivered to above address)
Application/supporting document(s) cannot be submitted via fax or e-mail

Information: 954 – 357 – 8400

Transportation Disadvantaged Application
DOOR-TO-DOOR PARATRANSIT SERVICE
Broward County Transit

APPLICANT NAME: _____ Date of Birth: _____

SECTION 3 – MEDICAL (TO BE COMPLETED BY A FLORIDA PHYSICIAN) (PLEASE PRINT)

Does applicant have Medicaid? YES _____ NO _____

If Yes, Medicaid #: _____ Medicaid Program Code: _____

Indicate mobility aides used and required treatments. Define how indicators in "Other" impact using the fixed-route bus system.

Mobility Aides	Other	Treatments
Crutches __ Walker __ Scooter __ Cane __ PWR W/C __ AMBI __ Leg Brace __ W/C __ Back Brace __ None __	Oxygen __ Hearing __ Visual __ Acuity __ Cognitive __	Chemo __ Radiation __ Dialysis __ Day(s):_____ Times: _____ Facility Name: _____ Facility Address :_____ _____ _____

Reason(s)/Condition(s) prevent applicant from using fixed-route bus service:
(Must include specific explanation(s) why applicant cannot ride fixed-route bus)

Diagnostic Code(s) _____ Diagnosis_____

Explanation *why* condition(s) prohibits use of fixed-route bus: _____

_____

_____

_____

_____

_____

_____

I, the undersigned, certify the medical information provided on this TD application is true and correct. I understand providing false or misleading information constitutes fraud and is considered a felony under the laws of the State of Florida. **RETURN COMPLETED, ORIGINAL DOCUMENT TO PATIENT**

_____ _____
Physician's Signature FL Medical License Number

_____ _____
Physician's Name (Print) Telephone Number