TRANSPORTATION DISADVANTAGED (TD) DOOR-TO-DOOR PROGRAM

Dear TOPS! Applicant:

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

Door-to-Door Paratransit Transportation: Shared-ride paratransit transportation is provided to eligible Broward County residents with physical, cognitive, emotional, visual, or other disabilities which functionally prevent them from using the BCT fixed-route bus system permanently, temporarily or under certain conditions. Door-to-door paratransit transportation is provided to health care, employment, education, shopping, social activities and other life-sustaining activities.

Eligibility: The TD program is a “last resort” program for disabled individuals in need of transportation and do not have access to any other transportation resource. TD eligibility criteria requires the applicant to qualify under both disability AND current Federal Poverty Level Guidelines, depending on the number of family members in household, at the 225 percent level. (see chart below) We are required to make every effort to verify your income and medical information to determine eligibility. Blanks on your application are considered as incomplete and may affect the timeliness of eligibility determination.

<table>
<thead>
<tr>
<th>Persons in family/household</th>
<th>225% of 2020 Federal Poverty Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$ 28,710.00</td>
</tr>
<tr>
<td>2</td>
<td>$ 38,790.00</td>
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<tr>
<td>3</td>
<td>$ 48,870.00</td>
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</table>

For households of more than three members please view our website at www.broward.org/bct to access the complete TD Income Guidelines chart.

Completed TD applications must contain all requested information. You are required to submit identification and applicable financial supporting documents when submitted. Self-declaration of income is not accepted. Faxed or Emailed applications are not accepted due to the collection of individually identifiable information.

**Complete application information prior to printing and submitting.**

Mail to: Paratransit Eligibility Services  
Broward County Transit  
1 N. University Dr., Suite 2400-B  
Plantation, FL 33324  
Information: 954-357-8400  
(Mail or hand deliver application to the above address)

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 County to give you this written statement explaining the purpose and authority for collecting your SSN.

<table>
<thead>
<tr>
<th>FORM</th>
<th>PURPOSE</th>
<th>AUTHORIZATION</th>
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<tbody>
<tr>
<td>TD Application</td>
<td>Conduct eligibility verification and monitor for system abuse</td>
<td>County policy (See Note)</td>
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</table>

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

Rev 2/20
Transportation Disadvantaged Application
DOOR-TO-DOOR PARATRANSIT SERVICES
Broward County Transit

Instructions:
Complete Sections 1 and 2. Section 3 must be completed by a Florida Licensed Physician. Attach all required documentation. Self-declaration of income is not accepted.

A copy of your Current Florida Driver’s License / Florida ID
Showing a Broward County address is required.

SECTION 1 – GENERAL INFORMATION (PLEASE PRINT LEGIBLY)
Name of Applicant: ____________________________
Home Address: ________________________________
Mailing Address (if different):
If using agency to receive mail, provide agency letter stating they will receive your mail
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: _______
Enter Total Annual Household Income Here (lines 1 through 8 below): ___________

For us to determine your household income, please submit a copy of all current annual income/benefit(s) received by you and/or any relative(s) living in the residence.*

1. Most recent pay stub with year-to-date reporting $__________________
2. DCF Benefits / Cash Assist. / Food Stamps with benefit amount $__________________
3. Unemployment Compensation $__________________
4. Social Security Awards Letter (SSA / SSI / SSDI) $__________________
5. Retirement / Pension / Investment $__________________
6. Disabled Veteran Benefits $__________________
7. Housing benefits (HUD, Section 8) (Not Happy Choice Voucher) $__________________
8. Other (Specify) $__________________

Self Declarations are not accepted as proof of lack of 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).

Additional documentation may be required to support household income.

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

VETERAN’S INFORMATION

Are you a United States veteran? YES ____ NO ____

If YES, type of Military Discharge:

Honorable ____ General (Honorable Conditions) ____

If YES, attach Proof of Honorable Discharge.

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

SECTION 2 – HOUSEHOLD MEMBERS (RELATIVES)

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<thead>
<tr>
<th>NAME</th>
<th>DATE OF BIRTH</th>
<th>RELATIONSHIP</th>
<th>SOCIAL SECURITY NUMBER</th>
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Did you attach a copy of your FL ID or Drivers license? Yes ____ No ____

Did you attach all required documents? Yes ____ No ____

Is the Medical Form completed by a Florida Licensed Physician? Yes ____ No ____

I attest all information is correct and if there are any changes, I will report them to TOPS! Paratransit Services immediately. (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., 2400 - B, Plantation, FL 33324
(Mail or hand deliver application to the above address)
Transportation Disadvantaged Application
Door-To-Door Paratransit Service
Broward County Transit
Section 3 – MEDICAL

Client ID: __________

Applicant Name: _______________________________ Date of Birth: __________

SECTION 3 – MEDICAL

(TO BE COMPLETED BY FLORDIA LICENSED PHYSICIAN)

Does applicant have Medicaid?  Yes ____ No ____ If Yes, Medicaid #: ______________

Medicaid Program Code: ________________

Indicate Mobility Aides / Equipment / Disability Condition(s):

Mobility Aides / Equipment:
Crutches ___ Scooter ___ W/C ___ PWR W/C ___ Walker ___ Cane ___ Leg Brace ___

Back Brace ___ AMBI ___ None ___ O2 Tank ___ Other ______________________________

Disability Condition(s):
Functional ___ Hearing ___ Visual ___ Cognitive ___

Please explain below how the applicant’s disability stops the applicant from independently using the BCT fixed-route bus? (BCT Buses are 100% handicapped accessible).

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

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.

_________________________________________  ______________________________
Physician’s Signature                        Florida Medical License Number

_________________________________________
Physician’s Name (Print Legibly)              Contact Number