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 by disability and/or 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.

Persons in family/household	225% of 2023 Federal Poverty Guidelines
1	$ 33,805.00
2	$ 44,370.00
3	$ 55,935.00

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.

Complete application information prior to printing and submitting.

Mail to: Broward County Transit - Paratransit Division
1 N. University Dr., Suite 2400-B
Plantation, FL 33324
Information: 954-357-8400 FAX: 954-357-8345

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.

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 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 02/23

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

Office Use Only
Client ID: _____
Date Approved: _____
Date Denied: _____

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:	Phone:
Home Address:	
Mailing Address (if different):	
If using an 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)

NAME	DATE OF BIRTH	RELATIONSHIP	SOCIAL SECURITY NUMBER

Did you attach a copy of your FL ID or Driver's license? Yes____ No____
Did you attach all required documents? Yes____ No ____
Is the Medical Form completed by a Florida Licensed Physician? Yes___ No ____

I certify, to the best of my knowledge, that the information in this application is true and correct. I understand providing false or misleading information or making false statements on behalf of others constitutes fraud, is considered a felony under the laws of the State of Florida and may result in a reevaluation or revocation of my eligibility.

_____ _____
Signature of Applicant Date

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

_____ _____
Print Name (Preparer) Relationship

Return to: Broward County Transit - Paratransit Division
1 N University Dr., 2400 - B, Plantation, FL 33324

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