SPACE COAST Area Transit

TD PARATRANSIT CERTIFICATION FORM

Space Coast Area Transit's Transportation Disadvantaged (TD) Service Program provides transportation services throughout Brevard County to the elderly, disabled, economically disadvantaged, children at risk, and those with no feasible means of transportation. The TD Paratransit Certification Form explains how an individual's disability prevents him/her from riding Space Coast Area Transit's Fixed Route Bus System. Applications in Braille, large print and on tape are also available upon request.

Applicants are eligible for 21 days of service while their information is being processed for certification. Additionaly, applicants are eligible for 21 days of out-of-town-service if they have documented TD Paratransit Certification from another public entity. After an applicant's TD Paratransit eligibility is certified, they will be notified by phone or e-mail. If eligibility is denied, a letter will be mailed to the applicant explaining the reason for denial and advising him/her of the process to appeal.

Applicants **MUST** include the following to prove eligibility: a Medicare Card, SSD Letter or SSI Award Letter, or a letter from a medical provider **and** a State ID for proof of age. If over 60 complete the information contained in **Section A and D** and sign **Section E. If under 60,** complete **Sections A, B, C, D,** and **E.** The **application MUST be signed to be processed.** Complete/submit the TD Application online and upload your required documents electronically at **321Transit.com/TDapply**, or, complete/submit the TD Application manually and return the signed application along with required documents to Space Coast Area Transit, 401 South Varr Ave., Cocoa, FL, 32922. For questions, assistance in filling out the application, or to schedule initial service, contact Customer Service at (321) 635-7815 ext. 52937 or e-mail **info@321Transit.com.**

SECTION A - PERSONAL INFORMATION

Last name: First Name: Middle Initial:

Home address: City:

Sub Division Name: State: Zip:

Mailing Address (if Different):

Home Phone: Work: Mobile:

Email: Date of Birth: Male: Female:

Emergency Contact: Relationship:

Contact's Home #: Work: Mobile:

List other family members/dependents who need and are eligible for transportation:

First/Last Name	Date of Birth	Relationship

SECTION B - AVAILABILITY OF OTHER TRANSPORTATION

1. Does applicant own a vehicle? Yes No Year, Make, Model:

2. State the reason why applicant cannot drive his/her vehicle (e.g. medical, vehicle troubles, etc):

3. Applicant is looking for permanent: or temporary: transportation service?

4. Does any other member of applicant's household own a vehicle?

5.Could any of applicant's household members, family, or friends provide transportation? Yes No

If no, please explain:

6. How is applicant currently being transported to appointments?

7. Does applicant live in a facility that can provide transportation?

If yes, please provide the facility name?

8. Is applicant enrolled in any other program(s) that will pay for or provide applicant with transportation services?

☐ Yes ☐ No If yes, please provide the name of the program(s):

9. What is the nature of the disability preventing applicant from using Fixed Route Bus Service?

10. How does this disability prevent applicant from using Fixed Route Bus Service? Explain.

SECTION C - COMMON DESTINATIONS

List all hospitals, doctors, medical facilities, employment, educational and other locations that applicant visits on a regular basis. Use an additional sheet of paper if more space is required.

SECTION D - SPECIAL NEEDS

List any special needs: ☐ Manual Wheelchair ☐ Powered Wheelchair ☐ Powered Scooter ☐ Walker ☐ Cane ☐ Respirator ☐ Service Animal ☐ Personal Care Attendant (PCA)

Does applicant have any other needs/conditions (cultural, religious, physical, psychological, etc.) that we need to be aware of in order to transport him/her safely? ☐ Yes ☐ No If yes, please explain:

SECTION E - CERTIFICATION AND ACKNOWLEDGEMENT

I understand and affirm that the information provided in this application for Non-Emergency Transportation Disadvantaged services is true and correct to the best of my knowledge and will be kept confidential and shared only with medical and transportation professionals involved in evaluating and determining my needs and eligibility for transportation to and from eligible services as well as appointments. **I understand that providing false or misleading information or making fraudulent claims or making false statements on behalf of others could constitute a felony under the laws of the State of Florida.**

Applicant's Signature Date

Only signed applications with a copy of a State ID and proof of disability will be processed.

SECTION F: FOR OFFICE USE ONLY – REVIEW RESULTS

Date Received:_____ New Application: (Y/N) Reviewed by:_____

Date Approved:_____ Date Denied:_____ Reason for Denial:_____

Letter:_____ Category Type:_____ Funding: Medicaid (Y/N) TD: (Y/N) New Application: (Y/N)