

# 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 type and on tape are also available upon request.

Applicants are eligible for 21 days of service while their information is being processed for certification. Additionally, 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 one of the following to prove eligibility: a Medicare Card, SSD Letter or SSI Award Letter, or a letter from a medical provider. If **age 60 or over**, also include a **State ID for proof of age** and complete the information contained in **Section A** and sign **Section E**. If **under age 60**, complete **Sections A, B, C, D, and E**. The **application must be signed to be processed**. 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](mailto:info@321Transit.com). Return the completed application to: **Space Coast Area Transit, ATTN: TD Paratransit, 401 South Varr Ave., Cocoa, FL 32922.**

## SECTION A - PERSONAL INFORMATION

Last Name:	<input type="text"/>	First Name:	<input type="text"/>	MI:	<input type="text"/>
Home Address:	<input type="text"/>			Subdivision:	<input type="text"/>
City:	<input type="text"/>	State:	<input type="text"/>	Zip:	<input type="text"/>
Mailing Address (if different):	<input type="text"/>				
Home Phone:	<input type="text"/>	Work:	<input type="text"/>	Cell:	<input type="text"/>
Email Address:	<input type="text"/>	Date of Birth:	<input type="text"/>	Male:	<input type="checkbox"/>
				Female:	<input type="checkbox"/>
Emergency Contact:	<input type="text"/>	Relationship:	<input type="text"/>		
Contact's Home #:	<input type="text"/>	Work:	<input type="text"/>	Cell:	<input type="text"/>

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

First/Last Name	Date of Birth	Relationship
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

## SECTION B - AVAILABILITY OF OTHER TRANSPORTATION

- Does applicant own a vehicle?  Year, Make, Model:
- State the reason why applicant cannot drive his/her vehicle (e.g. medical , vehicle troubles, etc):
- Applicant is looking for permanent:  or temporary:  transportation service?
- Does any other member of applicant's household own a vehicle?

# TD PARATRANSIT CERTIFICATION FORM

5. Could any of applicant's household members, family, or friends provide transportation?

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?  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?  If yes, please explain:

## SECTION E - CERTIFICATION AND ACKNOWLEDGMENT

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**

Applicants Signature:  Date