TRANSPORTATION AND PUBLIC WORKS

"Para información en español, por favor, llame al (786) 469-5000."
"Pou enfòmasyon an Creole, silvouplè, rele (786) 469-5000."

Dear Applicant:

This package was prepared and sent to you in response to your request for an application for Transportation and Public Works' Special Transportation Services (TPW/STS) which is our paratransit service. A copy of our "ADA Paratransit Application Form" is attached for your convenience. Please read this letter and the enclosed material carefully before attempting to complete this application. Information about your disability which you provide in the application will be kept strictly confidential.

Copies of this form are available in accessible formats upon request. If you have questions or need assistance completing this form, call TPW/STS at: (786) 469-5000 - TTY (305) 263-5459 or email: paratransit@miamidade.gov

Florida Relay Service (TTY) - 1(800) 955-8771 or 711

"ADA Paratransit" service is a shared-ride service, comparable to standard fixed route transportation (Metrobus/Metrorail/Metromover) services. This service is provided to individuals who, because of a functional disability, are prevented from using the fixed route transportation service. This might include not being able to get to or from bus stops, not being able to board or disembark buses, or not being able to understand (due to a cognitive or development disability) how to ride and use the fixed route service. The DTPW will provide van/accessible van shared-ride to persons that are "ADA Paratransit Eligible"

DO NOT MAIL IN YOUR
COMPLETED APPLICATION
CALL TO SCHEDULE AN APPOINTMENT
786-469-5000

To evaluate your eligibility for this service, please complete the enclosed application form and be as thorough as possible. It is important that all sections of the application form are completed. <u>If any sections are left blank, the form will not be accepted.</u>

It is The Department of Transportation and Public Works' policy to ensure compliance with the Health Insurance Portability and Accountability Act - 45CFR Parts 160 and 164 (HIPAA) Privacy Rule by obtaining authorization, as appropriate, from clients whose Protected Health Information (PHI) is used or disclosed for any purpose not otherwise permitted by Federal Medicaid Rules or/and the Privacy Rule.

Do not mail this application. Once completed, call Paratransit Operations at 786-469-5000 to schedule your certification interview. You may also request an interview appointment via email at: paratransit@miamidade.gov.

The Department of Transportation and Public Works goal is to continue to provide reliable and accessible transportation. Significant changes have been made to the county fixed-route transportation system to make it more accessible to persons with disabilities. All Miami-Dade Transit buses are now wheelchair-accessible. All Metrorail and Metromover stations have ramps and elevators and other accessibility features. Miami-Dade Transit provides additional free and reduced fare services to the public including reduced fare permits, Monthly and Discount Passes, Golden and the Patriot Passport.

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INSTRUCTIONS: (To be completed by the Applicant)

The applicant (or an assistant) must complete Parts I and II. A Florida licensed-physician must complete and sign the MEDICAL VERIFICATION PART III. Once you have this form completed and signed by your medical representative, **you must call the STS Certification Office at 786-469-5000 between 8:00 AM and 5:00 PM (Monday through Friday) to schedule an appointment for an in-person eligibility assessment. Be sure to bring this completed original application on the day of your appointment. DO NOT MAIL APPLICATION.**

If you have no other means of transportation, STS transportation will be provided to you to attend the in-person assessment. (Applicant rides fare free/Companions pay STS fare each way).

It is recommended that you obtain, from your medical representative, objective medical documentation which can substantiate your medical condition(s) and provide insight regarding your functional abilities or limitations when using the fixed route transportation system. If medical documentation is not attached to the application or if necessary, we may request further documentation from your medical representative before a determination is made.

Certification Department will provide Determination within 21 days after an in-person assessment has been conducted. You will receive a notification by mail of the determination, if you have not hear from us within 21 days, please call and we will provide you with paratransit service until you're determination of eligibility is process. Please note that in some instances, we may not be able to determine your eligibility without further information. In this case, we may request further documentation from your medical representative. You will receive notification by mail of the final determination.

ALL QUESTIONS MUST BE ANSWERED. INCOMPLETE AND/OR UNSIGNED FORMS WILL NOT BE ACCEPTED, AND MAY CAUSE A DELAY IN YOUR ELIGIBILITY DETERMINATION APPLICATION MUST HAVE ORIGINAL SIGNATURE.

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ID#______________
STS Application

SPECIAL TRANSPORTATION SERVICES (STS) APPLICATION FORM

I. APPLICATION SECTION:

S.S. # (9 digits) ______-______-______ Date of Birth: ____/____/____ Sex: [ ] Male [ ] Female

Receiving Medicaid: ( ) Yes ( ) No As of date____________ Medicaid. # ________-______-______

Last Name: ______________________ First Name____________________ M.I.:__________

Street Address: ____________________ Apt. #: ______ City: ______________ State: ________

Zip Code: ______ Home Phone :( ) ______________ Email address: ____________________

Is this a [ ] House [ ] Apartment [ ] Nursing Home [ ] ACLF [ ] Boarding Home

Applicant's weight: _____ lbs. Wheelchair (if applicable) weight _____ lbs. length _____, width_______

EMERGENCY CONTACT: Name and telephone number of someone we can call in an emergency.

Name: ______________ Relationship: __________ Phone: ( ) ____________________

ETHNICITY: (*for statistics only, optional)*
[ ] White Non-Hispanic [ ] Black Non-Hispanic [ ] Hispanic [ ] other *(specify)* ________________

A. If you use a wheelchair, can you transfer with minimal assistance into a sedan? Y___ N ___
Type of wheelchair: [ ] Manual [ ] Motorized [ ] Scooter *(Three wheeled)*
B. If someone assisted the client to complete this form, please specify;

Name: __________________Relationship: ______________ Phone: ( ) ____________
If you need to have information given to you in an accessible format, please specify:

____

II. APPLICANT'S RELEASE:

The following information is requested to evaluate when and under what circumstances the applicant can use the County bus, rail, or mover service and when Special Transportation Service (STS), shared-ride paratransit service, is required. I understand that the information about my disability contained in this application will be kept confidential and shared only with professionals involved in evaluating my eligibility. I certify that, to the best of my knowledge, the information in this form is true and correct. I understand that providing false or misleading information could result in my eligibility status being re-examined as well as prosecution to the maximum extend allowed by the laws of the State of Florida. I hereby authorize my medical representative to release any and all information required by the TPW Paratransit Certification Enrollment Office regarding my medical condition for the purpose of determining my eligibility to use Special Transportation Service (STS).

Applicant's Signature: ____ Date: ________________

If applicant is unable to sign this form, he/she may have someone sign and certify on applicant's behalf.

Signing for applicant: ____ Date: ________________

Print Name: ________________________________ Relationship to applicant: ________________

III. MEDICAL VERIFICATION (*to be completed by a Florida licensed physician)*

The Americans with Disabilities Act of 1990 (ADA) requires all public entities operating fixed- route transportation service for the general public to also provide complementary paratransit service to persons unable to use the fixed-route system. The Department of Transportation and Public Works (DTPW), Special Transportation Service (STS) provides complementary paratransit shared ride service to individuals certified as ADA paratransit eligible. The applicant who has asked you to review and sign this form is applying to TPW to be considered eligible for this service. This application form will assist TPW to evaluate when and under what circumstances the applicant can use Metrobus, Metrorail, or Metromover service and when they require paratransit service. ADA/STS shared-ride service is intended only for those trips that the person cannot make on the bus/rail/mover system.

STS ELIGIBILITY CRITERIA:

Applicants shall be individually evaluated, and eligibility shall be based on a functional ability to use conventional public transportation: Metrobus, Metrorail, and Metromover. Functional inability to use public transportation includes the Americans with Disabilities Act (ADA) Categories 1, 2 and 3 as described in this application.

A. AMERICANS WITH DISABILITIES ACT (ADA) CATEGORIES:

1. The individual is <u>unable</u>, as a result of a physical or mental impairment (*including a vision impairment),* and <u>without the assistance of another individual</u>, *(except the operator of a wheelchair lift or other boarding device),* to board, ride, or disembark from an accessible bus or rail vehicle.

2. The individual <u>needs the assistance of a wheelchair lift or other boarding assistance device</u> and is able, with such assistance, to board, ride, and disembark from accessible transit vehicles. *(The individual would be eligible if an accessible vehicle is not available.)*

3. The individual has a specific impairment-related condition which prevents the individual from <u>traveling to or</u> <u>from</u>: Metrobus; Metrorail; and/or Metromover <u>stops/stations</u>.

MEDICAL REPRESENTATIVE:

In order to process this applicant's request to become a qualified STS rider, we require that the medical certification section of this form be completed, to expedite applicant processing, please attach objective medical findings which substantiate the disability. Examples include:

Electroencephalogram (EEG) or Neuropsychological Evaluation with FSIQ,
Snellen (visual acuity) and/or Perimeter Chart (field of vision) Report(s)
Elisa Western Blot result reading CD4 + counts
X-ray, MRI, or CAT scan Findings
Respiratory FVC/FEV1

III. MEDICAL VERIFICATION *(to be completed by a Florida licensed physician)*

B. INDICATE THE TYPE AND NATURE OF THE INDIVIDUAL'S DISABILITIES).

CHECK AS MANY ITEMS AS MAY BE APPLICABLE. *(SEE STS ELIGIBILITY CRITERIA)*

1. **MOBILITY IMPAIRMENT** (Please attach detailed **clinical evidence** of disability):
   a. [ ] **Non**-ambulatory disability *(required wheelchair to travel)*. Please specify the condition which requires full time use of a wheelchair ____
   b. [ ] Ambulatory disability (ambulation may be limited, but able to walk with or without mobility aid, may use wheelchair but can transfer to a seat with little or no assistance).
      I. Amputation *(detail extremity)*:____
      II. [ ] Stroke without Hemiplegia III. [ ] Stroke with Hemiplegia
      IV. [ ] Brain Spinal Nerve Trauma
      V. [ ] Other: ____
      Date disability started: _______________
2. **NEUROLOGICAL DISABILITY** *(motor dysfunction)*:
   (Please attach detailed **clinical evidence** of disability)
   a. [ ] Multiple Sclerosis b. [ ] Epilepsy c. [ ] Muscular Dystrophy d. [ ] Cerebral Palsy
   e. [ ] Parkinson's f. [ ] Alzheimer's g. [ ] Other______________________________
3. **VISUAL DISABILITY** (Please attach detailed **clinical evidence** of disability)
   a. [ ] Totally blind
   b. [ ] Legally blind - If this person is legally blind complete the following:
   Corrected visual acuity: Right Eye________ Left Eye________ (Attach Snellen reports of both eyes)
   Corrected field of vision: Right Eye________ Left Eye ________ (Attach Perimeter chart reports both eyes)
4. **COGNITIVE DISABILITY:** (Please attach detailed **clinical evidence** of disability)
   a. Type of mental impairment:
   [ ] Emotional [ ] Autism [ ] Adult retardation [ ] Dementia
   [ ] OBS [ ] Alzheimer's [ ] Development Disability [ ] other
   b. Level of mental impairment: [ ] Mild [ ] Moderate [ ] Severe [ ] Profound, I.Q.:____________
   (Must Specify)
5. **UNCONTROLLED FATIGUE:** (Please attach detailed **clinical evidence** of disability)
   a. [ ] Radiation/Chemo b. [ ] Dialysis If either a. or b. is marked please provide the following:

   Treatment Schedule (or duration): _________ Treatment Start and expected End date: ________thru ________

   Treatment Center: ______________________ Address: ______________________________

   c. [ ] HIV (Attach Elisa, Western Blot result reading CD4 + counts.) d. [ ] Other_______________
6. **IMPAIRMENT RELATED CONDITION:** (Please attach detailed **clinical evidence** of disability)
   a. [ ] Arthritis (Please attach MRI/CAT/X – ray findings or/and operative reports of affected area(s))
      i. {Functional Classification ____ Anatomical Stage _____}
   b. [ ] Cardiac (Please attached Echocardiogram or/and operative findings)
      i. {Functional Classification _____ Therapeutic Classification _____ }
   c. Spinal
   d. [ ] Respiratory *(Must Specify)* {FVC _____ FEV1 ____} (Attach oximetric capability report)
   e. [ ] Other (Please specify) ______________________________

C. DESCRIBE IN DETAIL THE APPLICANT'S PRIMARY DISABILITY: (BE SPECIFIC)

____
____
____

D. IS THIS DISABILITY: [ ] Permanent [ ] Temporary (If temporary, date of disability _____ &length of recovery____)

E. IS THIS DISABILITY CONTROLLED BY MEDICATION? [ ] Yes [ ] No

Explain:

____
____

III. MEDICAL VERIFICATION *(to be completed by a Florida licensed physician)*

F. According to your diagnosis and medical opinion can the patient do any of the following?

Use the Bus system independently	[ ] Yes	[ ] No
Walk to the bus stop	[ ] Yes	[ ] No
Wait for the bus	[ ] Yes	[ ] No
Board the bus with assistance of a ramp or kneeling bus	[ ] Yes	[ ] No
See bus signs, stops and traffic signs	[ ] Yes	[ ] No
Understand how to use bus (fare, orientation in the system)	[ ] Yes	[ ] No
Transferring from one bus route to another or to Metrorail/Metromover	[ ] Yes	[ ] No

What other limitation can you identify that would prevent the patient from using public transportation?

____

____

These limitations apply: [ ] Always [ ] Usually [ ] Occasionally [ ] Rarely

G. MOBILITY AID: [ ] Wheelchair [ ] Walker [ ] Crutches [ ] Braces [ ] Service Animal
[ ] None [ ] Cane [ ] Other ____________________

H. REQUIRED MODE OF TRANSPORTATION: Indicate the type of transportation required by the applicant based on his/her functional ability.
[ ] Ambulatory (vehicle/van) [ ] Wheelchair (lift van)

I. BASED ON THE INDIVIDUAL'S DISABILITY, DO YOU RECOMMEND HIM/HER TO BRING A PERSONAL CARE ATTENDANT ON EACH TRIP? [ ] Yes [ ] No

J. PLEASE ATTACH PERTINENT MEDICAL DOCUMENTATION (E.G. EVALUATIONS, TEST RESULTS, NOTES, REPORTS, ETC.) THAT WOULD HELP TO EXPLAIN THE DIAGNOSIS OR LIMITATIONS ON THE APPLICANT'S ABILITY TO USE METROBUS, METRORAIL, OR METROMOVER.

NOTE: Failure to attach documentation will delay the eligibility determination process and will require that DTPW contact your office to obtain pertinent documentation before rendering a decision.

IN SIGNING, I ACKNOWLEDGE THAT, TO THE BEST OF MY KNOWLEDGE, THE INFORMATION IN THIS EVALUATION FORM IS TRUE AND CORRECT. FURTHERMORE, I CERTIFY THAT, I HAVE ATTACHED OBJECTIVE MEDICAL TESTS/DOCUMENTATION WHICH SUBSTANTIATES THE ABOVE STATEMENTS. I UNDERSTAND THAT PROVIDING FALSE OR MISLEADING INFORMATION COULD RESULT IN THE RE-EXAMINATION OF THE ELIGIBILITY STATUS OF THE APPLICANT AS WELL AS PROSECUTION TO THE MAXIMUM EXTENT ALLOWED BY THE LAWS OF THE STATE OF FLORIDA.

[ ] Yes, I have attached the required medical documentation

____ ____________________

Print or Type Name of Physician State of Florida License # Original Signature/ Date

____ (___)________ (___)________

Office Address City State Zip Code Telephone Fax #