



## TRANSPORTATION ASSISTANCE APPLICATION FOR PARATRANSIT SERVICE

Instructions to Applicant or Proxy:

- Please read the paratransit eligibility criteria found on page 3 carefully. If you feel that you meet these criteria, please fill out the Applicant sections of this form.
- Please be sure to print, complete all information requested and sign where appropriate.
- Have the Professional Verification sections completed and signed by the approved health care professional. All information provided will be verified and confirmed. You may attach supporting documentation.

StarMetro provides paratransit services in specially equipped vans to persons who cannot use the regular bus system. To be eligible for this service, individuals must have disabilities that prevent their use or access of the regular bus system. Neither age, income, access, or distances to the nearest bus stop by themselves are eligible disabilities. Any false or misleading statements will be cause for revoking paratransit eligibility.

Determination of paratransit eligibility may take up to 10 days to complete the process. You will be notified by mail of your eligibility status.

For your application to be accepted and evaluated, all requested forms and information must be complete when submitted. Incomplete applications will cause delays in eligibility approval. If assistance is needed in completing the application process, please call the CTC office at (850) 891-5199 or The Relay Service TDD at 711.

**Mail or deliver completed application to:**

**StarMetro, Community Transportation Coordinator  
555 Appleyard Dr.  
Tallahassee, FL 32304  
Phone: (850) 891-5199  
Fax: (850) 891-5143**

***Persons giving false or misleading information to StarMetro in order to obtain transportation may be terminated from the program.***

Please type or print when completing this form.

For Office Use Only

Dial-A-Ride

Net

Non Sponsored

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_-\_\_\_\_-\_\_\_\_ Medicaid #: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle \_\_\_M\_\_\_F

Home Address: \_\_\_\_\_  
Street Apt. # City State Zip Code

Phone #: \_\_\_\_\_  
Home Work Cell Email Address

Mailing Address: \_\_\_\_\_  
Street Apt. # City State Zip Code

Emergency Contact: \_\_\_\_\_  
Name Relationship Daytime Phone

\_\_\_\_\_ Address Apt. # City State Zip Code

**Check which condition(s), prevents you from accessing a regular StarMetro bus.**

\_\_\_\_\_ None, I would like transportation assistance. (Complete Section A only)

\_\_\_\_\_ The bus stop is too far or the bus does not run where I go. (Complete Section B only).

\_\_\_\_\_ My disability prevents me from using the fixed route bus system. (Complete Section C and D only).

**Applicants Release:**

I understand that the purpose of this evaluation form is to determine my eligibility for paratransit service. The information about my disability contained in this application will be kept confidential and shared only with the professionals involved in evaluating my eligibility. I hereby authorize my medical representative to release any and all information regarding my medical condition to StarMetro. I understand that providing false or misleading information could result in my eligibility status being revoked. I agree to notify StarMetro within 10 days, if there is any change in circumstances or I no longer need to use paratransit services.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

If applicant is unable to sign this form, he/she may have someone sign on his/her behalf.

\_\_\_\_\_  
Signing for Applicant

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

**SECTION A**

1. How do you currently travel to your destination? StarMetro bus \_\_\_ Taxi \_\_\_  
Drive Yourself \_\_\_ Other \_\_\_\_\_
2. Do you have friends or relatives who can take you? \_\_\_ Yes \_\_\_ No
3. What is your annual household income? \_\_\_\_\_  
**Must submit a copy of: Food Stamp card or Medicaid card.**
4. How many people (including yourself) are in your household? \_\_\_\_\_
5. Do you have weekly scheduled medical appointments (i.e. dialysis, etc.)? If yes, list:  
\_\_\_\_\_
6. How many medical appointments do you have a month? 1-2 \_\_\_ 3-4 \_\_\_ 5-6 \_\_\_  
More than 7 \_\_\_
7. Do you or anyone in your household have a car? \_\_\_\_\_ (Information may be verified by the Florida Dept. of Motor Vehicle)
8. Would you like to ride the bus with a bus pass? \_\_\_ Yes \_\_\_ No If "yes", please request a bus pass application.
9. Do you have any of the following? (Please check all that apply).  

___ I am on portable oxygen.	___ I have a mental impairment.
___ I have a sight impairment.	___ I am legally blind.
___ I am totally blind.	___ I have a hearing impairment.
___ I need assist walking.	___ I use a walker.
___ I use a cane.	___ I have a service animal.
___ I need an escort.	___ I have a personal care attendant.
___ I must travel by wheelchair.	___ I must travel by stretcher.
___ I use crutches.	

**SECTION B**

1. How far is the nearest bus stop? \_\_\_\_\_
2. Have you used StarMetro bus service in the past 6 months? \_\_\_ Yes \_\_\_ No      If no, why not? \_\_\_\_\_
3. What are your transportation needs? \_\_\_\_\_
4. How do you currently travel to your destination? StarMetro bus \_\_\_ Taxi \_\_\_  
Drive yourself \_\_\_ Other \_\_\_\_\_
5. Do you have weekly scheduled medical appointments (i.e. dialysis, etc.)? If yes, list:  
\_\_\_\_\_
6. How many medical appointments do you have a month? 1-2 \_\_\_ 3-4 \_\_\_ 5-6 \_\_\_  
More than 7 \_\_\_
7. Do you or anyone in your household have a car? \_\_\_\_\_ (Information may be verified by the Florida Dept. of Motor Vehicle).
8. Would you like to ride the bus with a bus pass? \_\_\_ Yes \_\_\_ No If "yes", please request a bus pass application.

**Please check all that apply to you:**

- |   |  |
|---|--|
| <input type="checkbox"/> I am on portable oxygen.     | <input type="checkbox"/> I have a mental impairment.       |
| <input type="checkbox"/> I have a sight impairment.   | <input type="checkbox"/> I am legally blind.               |
| <input type="checkbox"/> I am totally blind.          | <input type="checkbox"/> I have a hearing impairment.      |
| <input type="checkbox"/> I need assist walking.       | <input type="checkbox"/> I use a walker.                   |
| <input type="checkbox"/> I use a cane.                | <input type="checkbox"/> I have a service animal.          |
| <input type="checkbox"/> I need an escort.            | <input type="checkbox"/> I have a personal care attendant. |
| <input type="checkbox"/> I must travel by wheelchair. | <input type="checkbox"/> I must travel by stretcher.       |
| <input type="checkbox"/> I use crutches.              |  |

**SECTION C****Functional Ability (Please answer yes or no)**

Without the help of someone else, can you:

Cross a street?	<b>Y or N</b>	Handle coins and transfers?	<b>Y or N</b>
Read/hear/understand directions	<b>Y or N</b>	Wait outside without support for 15 minutes or more?	<b>Y or N</b>
Travel one block on a sidewalk?	<b>Y or N</b>	Grip handles and railings?	<b>Y or N</b>
Travel to nearest bus stop?	<b>Y or N</b>	Balance while seated?	<b>Y or N</b>
Stand at a bus stop?	<b>Y or N</b>	Give your address and phone #?	<b>Y or N</b>
Walk $\frac{3}{4}$ of a mile?	<b>Y or N</b>	Safely travel through crowded and/or complex facilities?	<b>Y or N</b>
Identify the correct bus?	<b>Y or N</b>	Recognize a destination or landmark?	<b>Y or N</b>
Climb a 12-inch step?	<b>Y or N</b>		

If you answered “no” to any of the above, please explain.

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What conditions or elements prevents you from getting to and from a regular bus stop:

There are no curb cuts \_\_\_\_ There are no sidewalks \_\_\_\_ Ground is not level \_\_\_\_

Slightly on an incline \_\_\_\_ Extreme weather \_\_\_\_ Busy intersection \_\_\_\_

Other \_\_\_\_\_

Do you use any of these mobility aids or equipment? (please check all that apply)

Portable oxygen \_\_\_\_ Service Animal \_\_\_\_ Walker \_\_\_\_ Cane \_\_\_\_ Crutches \_\_\_\_

Stretcher \_\_\_\_ Powered Wheelchair \_\_\_\_ Manual Wheelchair \_\_\_\_ Scooter \_\_\_\_

Leg Brace \_\_\_\_ Other (specify) \_\_\_\_\_

I do not use any of these mobility aids or equipment. \_\_\_\_

**NOTE: Mobility devices that exceed the ADA definition of a common wheelchair cannot be accommodated. All wheelchairs or scooters must be no longer than 48 inches, no wider than 30 inches and must not have a weight of more than 600 pounds when occupied.**

Do you have any of the following? (Please check all that apply)

\_\_\_\_ I have a mental impairment.

\_\_\_\_ I have a sight impairment.

\_\_\_\_ I am legally blind.

\_\_\_\_ I am totally blind.

\_\_\_\_ I have a hearing impairment.

\_\_\_\_ I have a personal care attendant

\_\_\_\_ I have a speech impairment.

Name: \_\_\_\_\_

**SECTION D**  
**Request for Professional Verification**  
**Must be completed by a licensed professional**

The applicant is requesting certification to use StarMetro paratransit service. StarMetro paratransit service is a curb to curb, shared ride program for individuals with physical or cognitive disabilities who are unable to use or access the regular public transportation system.

Please complete the medical verification sections of this application. The information you provide must be based solely upon the applicant having an actual physical or cognitive limitation, which prevents the use of our bus service. The diagnosis of a potentially limiting illness or condition is not sufficient determination for paratransit services.

What is the applicant's disability?

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How does this condition functionally prevent the applicant from using the regular bus service?

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What other normal life functions are prevented by the disability?

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Is the applicant's disability: Permanent \_\_\_\_ Temporary \_\_\_\_ If temporary until when? \_\_\_\_\_

Does applicant require a personal care attendant? **Y or N**

**I certify that the above information is true and correct to the best of my knowledge.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Professional License Number

\_\_\_\_\_  
Date Issued

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Contact Person