DEMAND RESPONSE SERVICE APPLICATION

In compliance with the Americans with Disabilities Act (ADA) of 1990, The Hernando County Public Transportation System, TheBus, provides Demand Response Service as a complementary Americans with Disability Act (ADA) to individuals with a disability who are traveling in an area served by TheBus, but who cannot use the regular fixed-route bus service. This application is intended to determine when and under what circumstances the applicant can use the regular fixed-route bus service and when demand response service is required.

INSTRUCTIONS FOR COMPLETING THIS APPLICATION

The applicant (or someone assisting the applicant) must complete **PARTS 1-7** (pages 2-7). A licensed professional must complete and sign **PART 8 - PROFESSIONAL VERIFICATION (**pages 8-11).

All applicants, whether new or being re-certified, must complete a new application. Demand response service certification process may involve a personal functional assessment to determine if the applicant can use the regular fixed-route service. Transportation will be provided to and from the assessment, if necessary. **All questions must be answered. Incomplete applications will be returned**. If you have any questions or need assistance in completing this application, please call TheBus at (352) 754-4890.

THE APPLICATION PROCESS MAY TAKE UP TO 21 DAYS

PLEASE RETURN THE COMPLETED APPLICATION TO:
Hernando County Transit Management
700 Aeriform Drive
Brooksville FL 34601

DO NOT WRITE IN THIS SPACE

New Application:_____	Re-certification:_____	
Date Received:_____	Approved:_____	Date:_____
Reviewed By:_____	Denied:_____	Date:_____
Date Interviewed:_____	Third Party Review:_____	Date:_____
PCA Needed:_____	ADA I.D. Number:_____	

PART 1 – GENERAL INFORMATION

PLEASE PRINT

Last Name:_____ First Name:_____
Street Address:_____ Apt #_____
Building Complex or Name:_____
City:_____ State:_____ Zip Code:_____
Mailing Address if different:_____
Telephone Number:_____ Date of Birth:_____
Social Security Number:_____
If someone is assisting you in completing this application, please identify him/her:
Name:_____ Phone Number:_____
Please give us the name and telephone number of someone we can contact in an emergency:
Name:_____ Phone Number:_____
Relationship:_____

PART 2 – ABILITY TO USE FIXED-ROUTE BUSES

Please indicate below the reasons you are applying for ADA Paratransit Eligibility:
(Check all that apply)

I can use TheBus fixed-route buses to go some places, but in other places I cannot get to and from the bus stops.

_____ I can use TheBus fixed-route buses, but only if they are equipped with wheelchair lifts or ramps.

Because of my disability, I can never use TheBus fixed-route buses.

Other reasons (please explain):_____
_____
_____
_____

PART 3 – INFORMATION ABOUT THE APPLICANT'S DISABILITY

1. What types of disabilities prevent you from using TheBus fixed-route buses? (Check all that apply)

_____ General Medical Condition
_____ Visual Impairment
_____ Developmental Disability
_____ Lung or Breathing Condition
_____ Brain/Nerve/Muscle Conditions
_____ Mental Illness
_____ Physical Disability
_____ Other

If Other, please explain in detail:_____
_____
_____

2. Is the disability described above temporary or permanent?

_____ Temporary, I expect it to last for another _____ months.
_____ Permanent
_____ I don't know

3. Please indicate below if you use any of the following mobility aids or equipment.

_____ Manual wheelchair
_____ Powered scooter
_____ Leg braces
_____ Cane
_____ Powered wheelchair
_____ Long white cane
_____ Walker
_____ Crutches
_____ Service animal (describe)_____
_____ Other (describe)_____
_____ I do not use any of the above aids or equipment

4. If needed, will a Personal Care Attendant (someone who must assist you with daily life functions) be riding with you?

_____ Yes _____ No

PART 4 – QUESTIONS ABOUT USING FIXED-ROUTE BUSES

5. Have you ever used TheBus fixed-route buses?

_____ Yes, I typically use TheBus fixed-route buses _____ times a week
_____ Yes, I used TheBus fixed-route buses but stopped because _____
_____
_____ No, I never use TheBus fixed-route buses because _____
_____

6. What might help you ride TheBus fixed-route buses? (Check all that apply)

_____ Route and schedule information
_____ Being able to get TheBus fixed-route buses with wheelchair lifts or ramps
_____ A communication aid (i.e., TDD, schedules in accessible formats)
_____ Learning to use TheBus fixed-route buses with travel training
_____ If bus stops were closer to where I live and where I need to go
_____ Other (please describe)_____
_____ None of these would help

7. Can you ask for and follow written/oral instructions to use TheBus fixed-route buses?

_____ Yes _____ No _____ Sometimes

If you selected **NO** or **SOMETIMES**, please check all that apply:
_____ I get confused and might get lost
_____ Other people cannot understand me
_____ I probably could with instructions
_____ Other (please describe)_____

8. Are you able to get to and from bus stops on your own?

_____Yes _____No _____Sometimes

If you selected **NO** or **SOMETIMES**, please check all that apply:

_____ I cannot get places if there are no curb cuts
_____ I cannot if the streets or sidewalks are too steep
_____ I cannot cross busy streets and intersections
_____ I cannot travel outside when it is too hot
_____ I cannot find my way at night because of my limited vision
_____ I probably could with travel training

_____ I feel unsafe traveling alone
_____ Other (please describe)_____

9. Using a mobility aid or on your own, how far can you walk or operate your wheelchair or scooter?

_____ I cannot walk outside my house or apartment
_____ I can get to the curb in front of my house or apartment
_____ I can walk or use my wheelchair up to 3 blocks
_____ I can walk or use my wheelchair up to 6 blocks
_____ I can walk or use my wheelchair up to 9 blocks

10. Can you wait up to 30 minutes for a TheBus fixed-route bus at a bus stop?

_____ Yes
_____ Yes, if the bus stop has a bus bench or shelter
_____ No (please explain)_____

11. Are there any other conditions that limit your ability to use TheBus fixed-route buses?

_____ Yes (please describe)_____
_____
_____ No

PART 5 – CURRENT TRAVEL INFORMATION

12. Please list the trips you will make most frequently using ADA Complementary Paratransit Service.

EXAMPLE

FROM:	TO:
35 Palm Dr.	**Publix, 150 Main St.**

	FROM:	TO:
(1)	_____	_____
(2)	_____	_____
(3)	_____	_____

PART 6 – INFORMATION ABOUT TRAVEL TRAINING

NOTE: Travel Training is personalized (individual or group) instruction that teaches the skills necessary to use TheBus fixed-route bus service.

13. Have you ever had any personal instruction on how to use TheBus fixed-route bus service?

_____ No, I have never received any Travel Training
_____ Yes, I have received personal Travel Training instruction through an agency
Name of Agency: _____

If you selected **YES**, please indicate below the skills you learned:

_____ To travel to and from bus stops
_____ To cross streets
_____ To read bus schedules and plan trips
_____ To ride the following routes:
Route #_____ Route #_____ Route #_____ Route #_____
_____ Other (please explain)_____

Did you complete the above training? _____Yes _____No

14. If TheBus offers free Travel Training to anyone interested in learning how to ride the Fixed-route bus service, would you be interested in getting information about this training?

_____Yes _____No

15. In the event of a mandatory evacuation, would you need transportation assistance moving for your home to a shelter?

_____ Yes _____ No

PART 7 – APPLICANT'S CERTIFICATION

I understand the purpose of this application is to determine if there are times when I cannot use TheBus fixed-route bus service and must therefore use the ADA Complementary Paratransit Service. I understand 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 application is true and correct. I authorize the licensed professional who provided professional verification to release information relating to my disability to TheBus in order to assess eligibility determinations.

Applicant's Signature:_____ **Date:**_____

THIS CONCLUDES THE PORTION OF THE APPLICATION TO BE COMPLETED BY APPLICANT.

THE LAST SECTION (PAGES 8-11) OF THIS APPLICATION MUST BE COMPLETED SIGNED BY A QUALIFIED AND LICENSED PROFESSIONAL.

EXAMPLES OF QUALIFIED PROFESSIONALS INCLUDE:

Physician (M.D. or D.O.)	Independent Living Specialist
Physical Therapist	Rehabilitation Specialist
Occupational Therapist	Licensed Social Worker
Orientation and Mobility Instructor	Optometrist
Registered Nurse	Psychologist

If applicants are deemed not eligible, a written reason for the determination and notice will be sent. All ineligible applicants have sixty (60) days to appeal that decision. After filing an appeal, the Transit Operator will, within 30 days, send a written notification of the appeal determination. All appeals will be heard by a reviewer who did not make the original decision. If a decision is not made within 30 days of completing the appeals process, transportation is provided until and unless a decision to deny the appeal is issued.

Hernando County Transit Management Inc.
(HCTM)
700 Aeriform Drive
Brooksville, FL 34601
(352) 754-4890

REQUEST FOR VERIFICATION OF DISABILITY

Dear Medical Provider:

Patient Name: _____

This form is necessary for the above named patient to utilize our transit services. He/she has indicated that you can verify his/her disability and its impact upon his/her ability. Federal law (the Americans with Disabilities Act of 1990) requires Hernando County Transit Management Inc. (HCTM) to provide paratransit services to persons who cannot utilize available fixed route services. The information you provide will allow us to make an appropriate evaluation of this request and its application to specific trip requests. Thank you for your cooperation in this matter.

NOTE: Disability verification is mandatory for all applicants for *HCTM* service. Any professional that verifies an individual's disability, must have detailed, first-hand knowledge of that person's disability, as well as the training and credentials necessary for such an evaluation.

• Please describe your professional status; i.e., Licensed Physician, Physical Therapist, Occupational Therapist, Specialist and describe your methods for evaluating the applicant's disability.

_____
_____
_____

• Medical/functional condition causing the disability, which will prevent the individual from using the regular bus service.

_____
_____
_____

Diagnosis & onset:

ICD – 9 codes:_____
DSM – IV codes:_____
OS – visual acuity & field: _____
OD – visual acuity & field:_____

• Is this condition temporary? _____ Yes _____ No
If yes, expected duration until _____/_____/_____

PHYSICAL DISABILITIES

• If the person has a disability affecting mobility, is the person able to travel either on his/her own or with a mobility aid 200 feet without the physical assistance of another person?
_____ Yes _____ No _____ Sometimes

• Is the person able to travel either on his/her own or with a mobility aid 200 yards without the physical assistance of another person?
_____ Yes _____ No _____ Sometimes

• Is the person able to travel either on his/her own or with a mobility aid ¼ mile without the physical assistance of another person?
_____ Yes _____ No _____ Sometimes

• Is the person able to climb three (3) 12-inch steps without the assistance of another person? (Handrails are available)
_____ Yes _____ No _____ Sometimes

• Is the person able to wait outside without support for ten (10) minutes?
_____ Yes _____ No _____ Sometimes

• Does this person require special assistance and /or the use of any mobility aids? If so, what?
_____
_____

• Are there any circumstances in which the applicant could not ride the regular, lift-equipped HCTM buses? Please describe.
_____
_____

• Does this person require a Personal Care Attendant (PCA) when traveling on public transit?
_____ Yes _____ No

• If this person falls, can he/she get up independently? _____Yes _____No _____Sometimes

• Can this person negotiate traffic safely and independently? _____Yes _____No _____Sometimes

• Can this person read information signs? _____Yes _____No
If no, please explain.

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• **NOTE: HCTM must be made aware of any special requirements of eligible passengers particularly if traveling with a respirator or portable oxygen supply. Please describe if applicable.**

• If there is any other effect of the disability of which HCTM should be aware, please describe (e.g., heat sensitivity, etc.).

Name of Professional

_____

Business Address

_____

City State Zip

_____

Telephone Number

_____

State of Florida License Number:_____

Signature:_____

Print Name: _____

Title: _____

Date_____