Transportation Eligibility Application

Passenger Information

Name: _____

Address: _____ **Apt #:** _____

City: _____ **State:** _____ **Zip:** _____ **Social Security #:** _____-_____-_____

Date of Birth: ____/_____/_____ **Phone #:** _____ ☐ **Home** ☐ **Cell**

Emergency Contact: _____ **Relationship:** _____

Emergency Contact: _____
Address City State Phone#

Email Address_____

Eligibility

Transportation Eligibility is limited to individuals who have little or no access to transportation due to income (150% of the Federal Poverty Level); are over the age of 60; or have a disability that prevents the individual from driving. You must include a copy of the selected documentation to be approved for service. Completing this application does not automatically certify you for service. Applicants may be required to undergo a functional assessment to assist FCPT in determining your level of eligibility.

Please include a copy of ALL supporting documentation for each selected section to confirm eligibility:

I am unable to transport myself or purchase transportation because I am:

☐ **Low Income –** Combined Annual Household Income: $_____

☐ DCF Benefit ☐ SSI Statement or Proof of Income ☐ Medicaid Card ☐ Housing Benefit
☐ Unemployment Compensation ☐ Other: _____

☐ **Over the age of 60** – Date of Birth: _____ Verified By:

☐ State Issued ID card and/or DL ☐ Copy of Birth Certificate ☐ Other: _____

☐ **Disabled –** Unable to operate a vehicle Verified By:

☐ Disabled Veteran Letter ☐ Doctor's Note ☐ Other: _____

Do you own a vehicle? ☐ YES ☐ NO Does anyone in your household own a vehicle? ☐ YES ☐ NO

How are you transported to appointments currently? _____

Do you have relatives/friends that can transport you? ☐ YES ☐ NO If no, why? _____

Do you live in a facility that provides transportation? ☐ YES ☐ NO Can the facility transport you? ☐ YES ☐ NO

If no, please explain why: _____

Please provide the name of the facility you reside, if applicable: _____

Do you have weekly scheduled appointments? ☐ YES ☐ NO Which days? ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S Time: _____

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Mobility Aids

Please select any and all special needs or mobility aids you may require:

☐ Manual Wheelchair ☐ Powered Wheelchair ☐ Powered Scooter ☐ Walker ☐ Cane
☐ Personal Care Attendant (PCA) ☐ Respirator ☐ Service Animal ☐ Child Car Seat ☐ White Cane

Do you have any other needs/conditions that we need to be aware of in order to transport you safely?

☐ YES ☐ NO

If YES, please explain: _____

_____

Certification & Acknowledgement

I understand and affirm that the information provided in this application is true and correct to the best of my knowledge. I understand that providing false or misleading statements constitute a felony under the laws of the State of Florida. I have read and understand all of the rules and policies that I am responsible for in the *FCPT Rider's Guide* I was provided with this application.

Flagler County Public Transportation collects your social security number for verification purposes only. Social Security numbers are a unique identifier and may be used for search purposes. Social Security numbers will never be shared.

Signature: _____ Date: ____/_____/_____

RETURN COMPLETED FORM TO:

FCPT
1769 East Moody Boulevard, Building 5
Bunnell, Florida 32110
EMAIL TO ***FCPT@flaglercounty.org***

DO NOT WRITE IN THE SPACE **RED INK ONLY** **OFFICE USE ONLY**

Applicant's Client ID#: _____ ☐ TD Funding Source ☐ FDOT Funding Source ☐ ADA

☐ New Eligibility ☐ Redetermination Received Date: _____/_____/_____

Reviewed By: _____ Date: _____/_____/_____

☐ Approved Criteria: ☐ Age 60+ ☐ Below 150% Poverty ☐ Disabled ☐ Other: _____

☐ Denied – Reason: _____

☐ Pending – Reason: _____

Applicant Notified Date: _____/_____/_____ Method: ☐ Phone ☐ Mail ☐ Email