JACKSONVILLE TRANSPORTATION AUTHORITY

100 N. Myrtle Ave. Bldg 2
Jacksonville, FL. 32204
904-265-6001

Thank you for inquiring about eligibility for ADA Paratransit Services. Enclosed is a copy of an ADA Paratransit Application form. Please read the following information before completing the application.

The JTA offers two categories of transportation: the mass transit system (city bus, Skyway, Community Shuttle and Ride Request services) and the JTA Connexion (paratransit service). The JTA's mass transit service provides accessibility features that make it possible for people with different types of disabilities to ride on its buses, Skyway trains and vans. These include: lifts and ramps (there is no need to use the steps if they cause you problems); tie-downs and passenger restraints (Driver-secured) for people using wheelchairs; stop announcements by the drivers and/or the Talking Bus automatic announcement and information systems for visually and hearing-impaired riders; and route schedules and information in alternative formats.

The JTA also offers to riders who may have a disability, receive Social Security Income or a Disabled Veteran the opportunity to ride the fixed route bus at a reduced rate. You can inquire about this program at 265-6001. In addition, if you are over the age of 65 you qualify to ride the fixed route bus for free.

The JTA Connexion is paratransit service that offers door-to-door service to eligible individuals who, due to disability, cannot access the mass transit system some or all of the time. This application is for certification to use the JTA Connexion service. This application consists of three sections: General Information; Americans with Disabilities Act (ADA) and State Transportation Disadvantaged (TD). Please be sure to fill out the application completely. An incomplete application may delay the processing and/or result in an inaccurate assessment of your abilities.

**When you complete the application and have gathered any supporting documentation as requested you must call the Eligibility Office at 265-6001 to schedule an appointment for your in-person interview and functional assessment. Please turn in application to Clerk on the day of your interview!**

During this assessment, you will meet with a staff member for an interview where they will ask additional questions concerning your ability to use the JTA, buses, Skyway and vans. Following your interview you will meet with a professional Functional Assessor for your functional assessment. This assessment will evaluate your travel abilities and limitations. You must bring all mobility devices that you use to travel outside your home and dress accordingly for the weather as some portions of the assessment will be conducted outside. **Also, please bring a picture ID.** We will take your photograph to be used for an ID, if you are deemed eligible**.** Once the interview and assessment is complete, you will receive your determination by letter within 21 days.

**Accessible versions of these forms are available upon request; Braille, large print or assistance with completing the application by one of the JTA Eligibility staff member**

# Jacksonville Transportation Authority
# Paratransit Eligibility Application

***DO NOT MAIL THIS APPLICATION***

All questions must be completed to process this application

## GENERAL INFORMATION (Please Print)

Last Name: _____First Name: _____ M. I. : _____

Residential Address: _____Apt/Lot#_____

City: _____ State: _____Zip: _____ County: _____

Is the provided address your mailing address? ☐ Yes ☐ No Email Address:_____

If not, please provide mailing address: _____

Daytime Phone Number: _____ Alternate Phone Number: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Emergency Contact: _____ Relationship: _____Telephone#:_____

Check the following residence type in which you live:

☐ Home ☐ Apartment/Townhouse ☐ Retirement Facility ☐ Assisted Living Facility ☐ Skilled Nursing Facility

Name of facility, if applicable: _____

When you travel outside your home, please indicate which (if any) of the following mobility aids you use:

☐ Power Wheelchair
☐ Manual Wheelchair
☐ Power Scooter
☐ No Mobility Aid
☐ Walker
☐ Cane
☐ Crutches
☐ White Cane
☐ Respirator
☐ Stretcher
☐ Service Animal
☐ Personal Care Attendant
☐ Other_____

If you use a manual wheelchair, can you transfer to a passenger seat for travel? ☐ Yes ☐ No ☐ N/A

Are you a disabled veteran? ☐ Yes ☐ No (If yes, please attach a copy of VA letter of disability)

Do you receive SSI or SSDI? ☐ Yes ☐ No (If yes, please attach copy of documentation.)

## SECTION A The Americans with Disabilities Act

A1. Can you use the JTA City Bus or Skyway? ☐ Yes ☐ No

A2. Please describe the condition, disability or limitation that prevents you from riding the JTA City Bus or Skyway _____

_____

_____

A3. Please describe how this condition or disability prevents you from riding the JTA Bus or Skyway

_____

_____

_____

## SECTION A The Americans with Disabilities Act Continued

A4. Is this condition/disability/limitation: ☐ Permanent ☐ Temporary

If temporary, how long do you expect it to last? _____

A5. With your mobility aids, if applicable, how far can you travel?

☐ I cannot travel outside my residence
☐ I can only get to the curb in front of my residence
☐ I can travel up to two or three blocks
☐ I can travel up to six blocks
☐ I can travel more than six blocks
☐ Not Applicable

A6. What is the longest time you can wait outside…

With a place to sit? ☐5 minutes or less ☐15 minutes ☐30 minutes ☐ More than 30 minutes
Without a place to sit? ☐5 minutes or less ☐15 minutes ☐30 minutes ☐ More than 30 minutes

A7. Can you negotiate up and down curbs when you travel between city blocks and/or cross streets?
☐ Yes ☐ No

A8. If you cannot use steps to board a bus, can you board a bus using any of the following? (Please note that persons who cannot climb the bus steps have the right to enter the bus by standing on the lift.)

A wheelchair lift? ☐ Yes ☐ No
A ramp (incline)? ☐ Yes ☐ No
If neither, please explain_____

A9. Are you able to give your address and phone number upon request? ☐ Yes ☐ No

A10. Are you able to ask for, understand, and follow directions? ☐ Yes ☐ No If No, please explain:

_____

_____

A11. Are you able to travel safely and effectively through crowded and/or complex facilities? ☐ Yes ☐ No

A12. How do you currently travel to your frequent destinations?

☐ JTA City Bus or Skyway
☐ JTA Connexion
☐ Taxi
☐ Someone drives me
☐ I drive myself
☐ School Bus
☐ Walk
☐ Other_____

A13. Do you travel with the help of another person? ☐ Always ☐ Sometimes ☐ Never

A14. Are you able to get to and from the public transit stop nearest your home? ☐ Yes ☐ No
If No, please explain: _____

_____

_____

A15. If you have a service animal, indicate the task(s) your service animal performs for you:

☐ Guides me
☐ Alerts me
☐ I do not currently use a service animal
☐ Picks up items
☐ Pulls me
☐ Carries items for me (explain) _____
☐ Other: _____
Type of animal: _____

A16. Please list other information you want us to know about your abilities:

_____

_____

_____

## SECTION B State Transportation Disadvantaged (TD) Program

B1. Do you or any member of your household own a vehicle? ☐ Yes ☐ No
List make, model and year for each: _____

B2. Do you have a Driver's License? ☐ Yes ☐ No
If yes: License Number: _____ State: _____ Expires: _____

B3. Can you or member in your household transport you to your appointments? ☐ Yes ☐ No
If not, why: _____

B4. Please list all other Household Members:

| Name | Relationship | Date of Birth | Drivers License Number (Y/N) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

B5. Are you currently receiving dialysis or oncology (cancer) treatments? ☐ Yes ☐ No
If yes, how many times per week? _____. Please provide the name of the facility where you receive these treatments: _____

B6. Do you live in a facility that provides transportation? ☐ Yes ☐ No
If yes, can this facility provide you with transportation to your medical appointments? ☐ Yes ☐ No
If no, why not:
_____

B7. Please attach a copy of one of the following:
☐ Birth Certificate ☐ JTA Senior ID Card (Sunshine Pass) ☐ Florida State ID Card
☐ Florida Driver's License ☐ Other Government photo ID with date of birth.

B8. Please list all facilities that you visit on a regular basis:

| Name and address of facility | Type of Visit | # of Monthly Visits | Describe How You Previously Got There |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

B9. Are there any other transportation needs of which we should be aware including culture competency?

_____

If all information is complete, please go to the next page, complete physicians information, sign and date application.

**DO NOT MAIL THIS APPLICATION.**

## PHYSICIAN CONTACT

To allow the JTA Connexion staff to make a fair assessment of your application, we may need to contact a medical professional who is familiar with your condition(s). Please complete the information below:

- Name of Medical Professional: _____
- Medical Facility: _____
- Address:_____
- City: _____ Zip: _____ County: _____ Phone: _____

Title of Medical Professional:

| | | |
|---|---|---|
| ☐ Physician | ☐ Optometrist | ☐ Licensed Mobility Specialist |
| ☐ Physician's Assistant | ☐ Rehabilitation Specialist | ☐ ESE Teacher |
| ☐ RN or LPN | ☐ Occupational Therapist | ☐ Social Worker |
| ☐ Psychologist | ☐ Physical Therapist | |

## APPLICANT SIGNATURE

I acknowledge the purpose of this application is to determine my ability to use transit and paratransit services. I understand that the staff of the Jacksonville Transportation Authority (JTA) and JTA Connexion may need to discuss my application to obtain additional information. I have been truthful in answering all of these questions and my information may be verified. I authorize the health care professional, including psychiatrists or psychologists, designated in this application to release and provide JTA and JTA Connexion, or its representatives, any additional information that may be required to complete or clarify this application. I agree that, when possible, I will travel to the nearest location that can serve my needs and understand that this will allow JTA to most efficiently serve the needs of the community.

I certify that, to the best of my knowledge, the information given is correct.

Please note that any person who knowingly makes a false or misleading statement in an application or certification under section 320.0848, Florida Statutes, commits a misdemeanor of the first degree, punishable as provided in section 775.082 or 775.083, F.S. The penalty is up to one year in jail or a fine of $1,000.

Applicant Signature:_____ Date:_____

If applicant signed their name above, but you helped this person to answer these questions, please sign and print your name below:

Signature: _____

Printed Name: _____

Relationship to Applicant: _____

Phone Number: _____

**AFTER THE APPLICATION IS COMPLETED CALL 265-6001 TO SCHEDULE AN INTERVIEW.**

**LARGE PRINT, BRAILLE AND ALTERNATIVE FORMATS AVAILABLE UPON REQUEST**

JACKSONVILLE TRANSPORTATION AUTHORITY

**CONNEXION ELIGIBILITY CENTER**
**100 N. Myrtle Avenue Building 2**
**Jacksonville, FL 32204**

**MEDICAL INFORMATION FORM**

_____ _____
**Applicant Name** **DOB**

**Medical Verification-To be completed by a licensed Medical Professional.**

**Please complete the section below. The information that you provide must be based solely upon the applicant having an actual physical or cognitive limitation, which prevents the use of our fixed route bus service. The diagnosis of a potentially limiting illness or condition is not sufficient determination for paratransit services.**

1. What is the applicant's disability?

   _____

   _____

2. How does the condition functionally prevent the applicant from using regular bus service?
   _____

   _____

3. If temporary, what is the duration?
   _____

4. Does this individual use a mobility aid? ___ yes ___no If yes, what type of mobility aid do they use?
   _____

   _____

5. If this individual is currently taking prescribed medication(s), does this medication enhance or diminish the individual's functional ability to travel independently? Please explain:
   _____

   _____

6. Are any of the following affected by the individual's disability? (Check all that apply)

| | | |
|---|---|---|
| ___Orientation | ____Monitoring time | ____Gait or balance |
| ___Problem solving | ____Judgment | ____Inconsistent performance |
| ___Short-term memory | ____Communication | ____Long-term memory |
| ___Inappropriate social behavior | | |
| ___Other (please explain) | | |

7. Please feel free to let us know if you have any other comments: _____

   _____

Signature of Medical Professional _____ Date_____

Professional License # _____ State Issued _____

Print Name_____
Address_____
City _____ State_____ Zip Code _____
Phone # _____ Extension _____
Contact person _____

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_____

Applicant 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