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. 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

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  ☐ Walker  ☐ White Cane  ☐ Service Animal

☐ Manual Wheelchair  ☐ Cane  ☐ Respirator  ☐ Personal Care Attendant

☐ Power Scooter  ☐ Crutches  ☐ Stretcher  ☐ Other_______________

☐ No Mobility Aid

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 __________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________
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 travel up to six blocks
   ☐ I can only get to the curb in front of my residence ☐ I can travel more than six blocks
   ☐ I can travel up to two or three 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 ☐ Someone drives me ☐ Walk
   ☐ JTA Connexion ☐ I drive myself ☐ Other_______________________
   ☐ Taxi ☐ School Bus

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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Date of Birth</th>
<th>Drivers License Number (Y/N)</th>
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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:

<table>
<thead>
<tr>
<th>Name and address of facility</th>
<th>Type of Visit</th>
<th># of Monthly Visits</th>
<th>Describe How You Previously Got There</th>
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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.
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: ______________________________

LARGE PRINT, BRAILLE AND ALTERNATIVE FORMATS AVAILABLE UPON REQUEST

AFTER THE APPLICATION IS COMPLETED CALL 265-6001 TO SCHEDULE AN INTERVIEW.
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
   ___ Problem solving
   ___ Short-term memory
   ___ Inappropriate social behavior
   ___ Other (please explain)
   ___ Monitoring time
   ___ Gait or balance
   ___ Judgment
   ___ Communication
   ___ Inconsistent performance
   ___ Long-term memory

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