



100 N. Myrtle Ave. Bldg G
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. 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?

- | | |
|------------------------------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> I cannot travel outside my residence | <input type="checkbox"/> I can travel up to six blocks |
| <input type="checkbox"/> I can only get to the curb in front of my residence | <input type="checkbox"/> I can travel more than six blocks |
| <input type="checkbox"/> I can travel up to two or three blocks | <input type="checkbox"/> Not Applicable |

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

- | | | | | |
|-------------------------|--------------------------------------------|-------------------------------------|-------------------------------------|-----------------------------------------------|
| With a place to sit? | <input type="checkbox"/> 5 minutes or less | <input type="checkbox"/> 15 minutes | <input type="checkbox"/> 30 minutes | <input type="checkbox"/> More than 30 minutes |
| Without a place to sit? | <input type="checkbox"/> 5 minutes or less | <input type="checkbox"/> 15 minutes | <input type="checkbox"/> 30 minutes | <input type="checkbox"/> 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?

- | | | |
|-------------------------------------------------|--------------------------------------------|--------------------------------------|
| <input type="checkbox"/> JTA City Bus or Skyway | <input type="checkbox"/> Someone drives me | <input type="checkbox"/> Walk |
| <input type="checkbox"/> JTA Connexion | <input type="checkbox"/> I drive myself | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Taxi | <input type="checkbox"/> 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:

- | | | |
|---------------------------------------------------------------|------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Guides me | <input type="checkbox"/> Alerts me | <input type="checkbox"/> I do not currently use a service animal |
| <input type="checkbox"/> Picks up items | <input type="checkbox"/> Pulls me | |
| <input type="checkbox"/> Carries items for me (explain) _____ | | |
| <input type="checkbox"/> 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:

- | | | |
|------------------------------------------------|----------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Optometrist | <input type="checkbox"/> Licensed Mobility Specialist |
| <input type="checkbox"/> Physician's Assistant | <input type="checkbox"/> Rehabilitation Specialist | <input type="checkbox"/> ESE Teacher |
| <input type="checkbox"/> RN or LPN | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> 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.**



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)

- | | | |
|--------------------------------------------------------|------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Orientation | <input type="checkbox"/> Monitoring time | <input type="checkbox"/> Gait or balance |
| <input type="checkbox"/> Problem solving | <input type="checkbox"/> Judgment | <input type="checkbox"/> Inconsistent performance |
| <input type="checkbox"/> Short-term memory | <input type="checkbox"/> Communication | <input type="checkbox"/> Long-term memory |
| <input type="checkbox"/> Inappropriate social behavior | | |
| <input type="checkbox"/> 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 _____