

Dear Applicant:

Thank you for inquiring about our Transportation Program. Since many of our programs are subsidized through State funding, it is necessary that you complete an application to determine your eligibility.

Please be sure to fill out all of the requested information on the application. That way we will not have to delay your use of the program by having to return your application for additional information.

The first section provides us with general information. Please complete the date, your **social security number**, and then *print* your name, address, phone number, and your date of birth. The next set of questions will help us determine the proper type of vehicle to transport you in and make us aware of any special needs you may have. (PLEASE ANSWER ALL QUESTIONS)

Please note, if you have dependants under the age of 18 that will also need to use our service, you must complete a **Dependant Information Form**. A separate application is not required. A completed Dependant Information Form must be completed for each dependant needing transportation.

The next section, Program Eligibility, requires you to complete all the information that will be used to determine your eligibility. It is very important that you read each section carefully, and answer all the questions accurately.

The final section of the application is Proof of Eligibility. Please be sure to send any necessary documentation requested in this section. This provides proof that you meet the necessary criteria to qualify you under one of the programs. Also attached is a copy of the Medical Verification Form that will be completed by a doctor or agency for only those clients claiming a medical eligibility or disability.

If requested transportation can be met by the “WAVE, WAVE Shuttle or EXPRESS”, you will be required to use this transportation and route directions will be given for pick-up and drop-off times and bus stop locations.

Please be sure to complete the entire application as legibly and accurately as you can. All information requested will be kept confidential and will not be released to any other individuals or agencies.

Thank you for your cooperation.

Okaloosa County Transit

ABOUT OCT PARA TRANSIT

(Door to Door Service)

If you qualify for the Transportation Disadvantaged program you will only pay a portion of the total cost of your trip. Payment is due to each driver you ride with as soon as you board the vehicle and cannot be billed. Transportation coupons can be purchased in our office or sent through your driver for a cost of \$20.00 per book containing 20 one dollar coupons.

- All applicants must show proof of Okaloosa County residency. All applications require a photo copy of a Florida picture I.D. or Florida driver license.
- All medical appointments are given priority.
- Medicaid recipients must receive Medicaid compensable services in Okaloosa County unless service is not available in Okaloosa County. If your PCM requests that you travel out of the county for a specialist, we must have a copy of a written referral from him/her stating that the service cannot be obtained here.
- Out of county medical appointments must be scheduled on designated days and times. All appointments are subject to verification.
- Employment transportation is available provided you live and work in the same city and the distance from your home to your job cannot be greater than ten (10) miles. **(Employment transportation is subject to availability.)**
- Shopping trips are available on designated days and times only. Passengers are limited to three (3) shopping bags on the vehicle.
- Personal trips such as: beauty salon, bank, restaurants etc..., are not subsidized. They will be provided at full cost to the passenger and are dependant upon availability.

Thank you,
OCT Staff

ABOUT OCT PARA TRANSIT
(Door to Door Service Crestview Area)

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Thank you,
OCT Staff

Application for Transportation

For Administrative Office Use Only:

Date Received _____ Received By _____

Complete Incomplete Needs _____

The information provided is used solely to determine your eligibility for subsidized transportation and will not be released to any other agency or individual.

It is important to **complete all** parts of this form. Applications not fully completed will be placed on hold, which will delay the certification process and your access to transportation.

PLEASE PRINT:

GENERAL INFORMATION

Date: _____

Medicaid Number: _____

****ALL MEDICAID TRANSPORTATION / APPOINTMENTS ARE SUBJECT TO VERIFICATION BY OCT****

Name: _____
(FIRST) (MIDDLE) (LAST)

Address: _____ Apt #: _____

City: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Date of Birth: _____ / _____ / _____ Female Male

Social Security Number: _____ - _____ - _____

Do you live in a Nursing Home, ACLF or Boarding Home? Yes No

If **YES**, does this facility have a vehicle to transport residents? Yes No

Have you ever been transported by this facility? Yes No

If someone assisted you in completing this application, please identify them.

Name: _____ Phone Number: _____

Please give us the name and telephone number of someone we can contact in an emergency.

Name: _____ Phone Number: _____

Dependant Application Attached Yes No

CURRENT TRAVEL INFORMATION

How are your transportation needs currently being met? _____

If you need transportation to work, please give the location. _____

Do you have a valid driver's license? Yes No

How many vehicles are available for use in your household? 0 1 2 or more

If you have a vehicle in your household and cannot use it due to medical reasons, please have your doctor or case manager complete the Medical Verification form attached to this application.

If you indicated a vehicle(s) available for use, why is it not used to transport you to your appointments? _____

Do you have any other means of transportation? (Family, friends, neighbors, etc.) Yes No

Program Eligibility

To determine your eligibility for assisted transportation you must complete each of the following items. Do not omit any information that might assist in determining your eligibility for transportation.

INFORMATION ABOUT APPLICANTS DISABILITY

Do you have any of the following disabilities? **(Check all that apply)**

Physical Disability Mental Disability Visual Disability

Hearing Impairment Other, please explain in detail _____

Is the disability described above temporary or permanent?

Temporary, I expect it to last for another _____ months.

Permanent I don't know

If you do not use a wheelchair and your disability impairs your ability to walk short distances or stand for short periods of time please have your doctor complete the medical verification form attached to this application.

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

Powered scooter Manual wheelchair Walker

Powered wheelchair Cane Service animal

Other (describe) _____

NOTE: We will not be able to accommodate you if your wheelchair or scooter is longer than 48 inches or if the total weight (when occupied) is more than 600 pounds.

PROOF OF ELIGIBILITY

Number of people living in household: _____

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PROOF OF ELIGIBILITY TO INCLUDE

If you have a medical disability, a Doctor or your sponsoring agency must complete the “Medical Verification Form” and return it to our office.

To determine your qualification for the Transportation Disadvantaged program, please attach a **photo copy** of all applicable documentation such as:

PLEASE CHECK ALL THAT APPLY

- **All Applicants must provide proof of Okaloosa County residency** (driver license, voter registration card, utility bill, etc)
- **Employment pay statement** and or a letter from your employer on company letter head stating how many hours you work and your hourly wage.
- **Child support** (copy of court order or bank deposit)
- **Alimony** (Copy of court order or bank deposit)
- **Social Security and or any Social Security Supplement** (copy of letter of entitlement or bank statement)
- **TANF** (copy of letter of entitlement)
- **Foster care income** (copy of letter of entitlement)
- **Food stamps** (copy of letter of entitlement)
- **Rent assistance / energy assistance** (copy of letter from assisting agency with amount)

TOTAL ANNUAL COMBINED HOUSEHOLD INCOME: \$ _____

All income must be shown for applicant, spouse or parent/guardian and any other dependents receiving any form of income listed above.

► This application is only good for one person age 18 or older. If you have minor dependents requiring transportation, complete a Minor Dependent Information Form for each dependent. ◀

APPLICANT'S CERTIFICATION

I understand the information contained in this application will be kept confidential and shared only with professionals involved in evaluating my eligibility for Para transit service. I certify the information provided in this application is true and correct, and I have no other means of transportation. I understand that providing false or misleading information, or making false statements on behalf of others constitutes fraud and is considered a felony under the laws of the State of Florida.

Applicants Signature: _____ Date: _____

Preparers Signature: _____ Date: _____

Print Preparers Name: _____ Phone: _____

**Return to: Okaloosa County Transit
600 Transit Way
Fort Walton Beach, Florida 32547**

For Office Use Only:	
Qualified: Yes <input type="checkbox"/> No <input type="checkbox"/>	Program: _____
Initials: _____	Date: _____
Returned for additional information: _____	Date: _____
Data input date: _____	Initials: _____
Support documentation attached: _____	

MEDICAL VERIFICATION FORM

I have examined / interviewed _____ and believe that he / she needs special transportation services because of the following physical condition(s).

- Unable to operate a motor vehicle
- Cannot board a vehicle without special equipment (lift, ramp)
- Cannot walk short distances or stand for short periods of time
- Must be transported on a stretcher
- Patient confined to a wheelchair
- Other reasons they must be transported utilizing a special vehicle

Please explain: _____

If patient is confined to a wheelchair, please indicate type.

- | | | |
|--|------------------------------------|--|
| Standard <input type="checkbox"/> | Motorized <input type="checkbox"/> | Three wheeled amigo <input type="checkbox"/> |
| Extra wide <input type="checkbox"/>
(Please indicate width) | High back <input type="checkbox"/> | Other (Please describe) <input type="checkbox"/> |

Please explain: _____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

(Signature of physician / case worker)

(Phone)

(Address)

(State License Number)

(City) (State) (Zip)

(Date)

MINOR CHILD INFORMATION FORM

Okaloosa County Transit

Please complete the following information for the minor child you are requesting transportation for.

PLEASE PRINT:

Date: _____	Social Security Number: _____ / _____ / _____
Name: _____ (First) (Middle) (Last)	
Relationship: _____	
Address: _____ (Number) (Street) (Apt. Number)	
City: _____	Zip Code: _____
Home Phone: _____	Work Phone: _____
Birth Date: _____ / _____ / _____	Male <input type="checkbox"/> Female <input type="checkbox"/> Medicaid Number: _____
Mobility Devices: Amb <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Crutches <input type="checkbox"/> Cane <input type="checkbox"/>	
Other type of impairment: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____	

PARENT OR LEGAL GUARDIAN:

Please Print (First) (Middle) (Last)

(Signature) _____ / _____ / _____
(Date)

FOR OFFICE USE ONLY:

Qualified: Yes No Program: _____

Date: _____ / _____ / _____ Initials: _____

ATTACH TO PARENT OR GUARDIAN APPLICATION