



RECERTIFICATION APPLICATION

Revised Oct. 2019

Completed applications accepted via mail/fax/email or in person at:
Palm Tran CONNECTION
50 South Military Trail, Suite 101
West Palm Beach, Florida 33415
Monday-Friday
8am-4:30pm

Main Office: 561-649-9838 option 7

Toll Free: 1-877-870-9849 toll-free outside local calling area

Eligibility Fax: 561-656-7156

Email: connpalmeligibility@pbcgov.org

**Program requires recertification at this time
AMERICANS WITH DISABILITIES ACT (ADA)**

INSTRUCTIONS FOR COMPLETING YOUR RECERTIFICATION APPLICATION:

In compliance with the Americans with Disabilities Act of 1990 (ADA), Palm Tran CONNECTION (PTC) provides paratransit (i.e., van/shared ride) service to individuals who because of their disability cannot travel by fixed-route bus. This application form is intended to determine eligibility for paratransit service.

You are receiving this notification, because the program you qualified for is up for recertification within the **next 30 days**.

Applications received in the mail, via fax or email, are processed in the order in which they are received. Processing time can take between 7 to 21 days from receipt.



50 South Military Trail, Suite 101
 West Palm Beach, FL 33415
 561-649-9838 or 1-877-870-9849 (toll-free)
www.palmtran.org

The contents of this document may change at any time without notice. Please contact Palm Tran CONNECTION for any updates or changes. If you have questions about any of the information contained in this document or to request this document in an alternative format, please contact Palm Tran CONNECTION'S administrative office at 561-649-6948

When Can I Ride?

PROGRAM	TIME OF SERVICE	HOLIDAY HOURS
Americans with Disabilities Act (ADA) Transportation Disadvantaged (TD)	Monday to Friday 4:45 am to 11:00 pm First pick-up no earlier than 4:45 am to 5:15 am Last pick-up no later than 10:00 pm to 10:30 pm	NO SERVICE ON THE FOLLOWING DAYS New Years Day Easter Sunday Memorial Day Independence Day Labor Day Thanksgiving Day Christmas Day
	Saturday 6:00 am to 10:35 pm First pick-up no earlier than 6:00 am to 6:30 am Last pick-up no later than 9:35 pm to 10:05 pm	
	Sunday 7:45 am to 8:15 pm First pick-up no earlier than 7:45 am to 8:15 am Last pick-up no later than 7:15 pm to 7:45 pm	
	PLEASE NOTE TIME MAY VARY BASED ON DISTANCE	
Division of Senior Services (DOSS)	Monday thru Friday 8:00 am to 5:00 pm No Service on Saturday & Sunday	

Reserving Your Ride

To reserve your ride, you will need to call the reservation line at **(561) 649-9838** or 1-877-870-9849 (toll-free for south county residents). **Press Option #3**. You can reserve a trip Monday through Sunday from 8:00 am to 5:00 pm. You may also reserve a trip up to seven days before you wish to travel. Next day reservations must be made by **5:00 pm.**, the day before you wish to travel.

When reserving your ride, you will need to provide the following information:

- Your ID number, full name or telephone number
- The date you wish to travel
- The complete address with zip code and telephone number where you will **begin** your trip, plus building name, suite # and cross street
- The complete address with zip code and telephone number where you will **end** your trip, plus building name, suite # and cross street
- Your appointment time and time you wish to return (Allow sufficient time; we recommend at least one hour between scheduled drop-off and return time).
- Indicate if you are traveling with a PCA, escort or service animal, etc.
- Other helpful information such as directions to a difficult address, specific entrance, one-way streets, etc.

RECERTIFICATION APPLICATION

PART 1. GENERAL INFORMATION

Please Print

ID # _____

Last Name: _____ First Name: _____

Street Address: _____ Apt#: _____ Bldg#: _____
Address must clearly visible from the street

Building/Complex or Development Name: _____
(or closest cross street/major intersection)

City: _____ State: _____ Zip: _____

Telephone: _____ Date of Birth: _____

EMAIL ADDRESS: _____

In case of emergency, please notify:

Contact Name/Relationship/Address	Contact Phone Number

PART 2. APPLICANT CERTIFICATION

I understand that the information about my disability contained in this application will be kept confidential and shared only with professionals involved in evaluating my eligibility for the provision of transportation services. Your information will also be available to other transit providers as necessary for appropriate transportation services. The information will not be provided to any other person or agency. I certify that, to the best of my knowledge, the information in this evaluation form is true and correct. Any person who knowingly makes a false or misleading statement in an application may be denied eligibility for Paratransit services.

Applicant's Signature: _____ **Date:** _____

If applicant is unable to sign due to disability, a Power of Attorney or Health Care Proxy document is required.

If someone assisted you in completing this form, please provide contact information:

Name: _____ Phone: _____

In Case of an Evacuation:

In the event of a mandatory evacuation order issued by Palm Beach County Emergency Management due to a Hurricane or Flood, would you need transportation to a shelter?

Yes No

If you require medical supervision or are electricity dependent, if qualified, you can be evacuated to a Special Care Shelter. To register for the Special Care Unit, please contact the Palm Beach County Emergency Operations Center at (561) 712-6400. 1

PART 3. DISABILITY VERIFICATION

A. What type(s) of disabilities prevent you from using Palm Tran buses? (check all that apply):

- Mobility impairment (Stroke brain spinal nerve trauma)
- Neurological Disability (MS, MD, Cerebral Palsy, Epilepsy, Alzheimer's Parkinson's, other)
- Visual disability (Macular Degeneration, visually impaired, legally blind)
- Uncontrolled Fatigue (Chemo/Radiation, Dialysis)
- Cognitive or Sensory Impairment (Autism, down syndrome, dementia, developmental, other)
- Impairment Related (Hearing impaired, Cardiac/COPD, respiratory, arthritis, neuropathy)

Please describe your disability in more detail:

B. Please indicate below if you use any of the following mobility aids or equipment (check all that apply)

- Cane
- Crutches
- Leg Braces
- Oxygen
- Service Animal
- Sighted (person) Guide
- Walker
- Manual Wheelchair
- Powered Wheelchair
- Powered Scooter/Cart
- White Cane (blind)
- Portable Medical Equipment (oxygen tank, etc.)
- Other (please specify) _____
- I don't use any of the above mobility aids or equipment.

Note: We may not be able to accommodate you if your wheelchair/scooter is longer than 54 inches or wider than 34 inches or if your total weight when occupying your wheelchair exceeds 600 pounds.

Do you require the assistance of a Personal Care Attendant (PCA) someone who must travel with you to assist you with daily life functions? **PCA is not provided by Palm Tran Connection.**

No **Always** **Sometimes**

Please note that we may require you to travel with a PCA if your condition or disability is severe.

C. Is the disability described above temporary or permanent?

- Temporary, I expect it to last for another _____ months
- Permanent I don't know

If applying for the Americans with Disabilities Act Program or the Transportation Disadvantaged Program, please have your PHYSICIAN COMPLETE THE ATTACHED (MEDICAL VERIFICATION FORM)



MEDICAL VERIFICATION
(THIS PORTION TO BE COMPLETED BY APPLICANT)

Please Print/Type Below

I certify that I am a person with a disability as described by the Americans with Disabilities Act. I further state that my physician or other certifying practitioner has completed the statement of certification below on my behalf, as required.

Name of Applicant as printed on the Identification

Signature of Applicant, Parent or Guardian of Applicant

Date of Birth

Sex

Date Signed

Street Address

City

State

Zip Code

MEDICAL VERIFICATION, CONTINUED
(THIS PORTION TO BE COMPLETED BY A LICENSED PHYSICIAN)

Keeping in mind that all Palm Tran buses are 100% wheelchair accessible; can the applicant ever use a regular bus?

- Yes No Sometimes

1. MOBILITY IMPAIRMENT:

- Non-ambulatory disability (requires wheelchair to travel) Please specify the condition which requires full time use of a wheelchair. _____
- Ambulatory disability (ambulation may be limited, but able to walk with or without mobility aid, may use wheelchair but can transfer to a seat with little or no assistance).
- Amputation (detail extremity): _____
- Stroke
- Brain Spinal Nerve Trauma
- Other: _____

2. MOBILITY AID: PLEASE INDICATE ALL THAT APPLY

- | | | |
|--|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Standard Wheelchair | <input type="checkbox"/> Cane | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Wide Wheelchair | <input type="checkbox"/> Walker | _____ |
| <input type="checkbox"/> Scooter | <input type="checkbox"/> Crutches | _____ |
| <input type="checkbox"/> Wide Scooter | <input type="checkbox"/> Braces | |
| <input type="checkbox"/> Service Animal | | |

3. NEUROLOGICAL DISABILITY (MOTOR DYSFUNCTION):

- | | | |
|---|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> Alzheimer's | _____ |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Parkinson's | |

4. VISUAL DISABILITY:

- Macular Degeneration
- Visually Impaired
- Legally Blind – If this person is legally blind, please complete the following:
 Corrected visual acuity: Right Eye _____ Left Eye _____ (Please attach Snellen reports of both eyes)
 Corrected Field of Vision: Right Eye _____ Left Eye _____ (Please attach Perimeter chart reports of both eyes)

5. UNCONTROLLED FATIGUE:

- Chemo/Radiation Dialysis



**MEDICAL VERIFICATION, CONTINUED
(TO BE COMPLETED)**

6. COGNITIVE OR SENSORY IMPAIRMENT:

- | | | |
|---|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Dementia | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Alzheimer's | |
| <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> Emotional | _____ |

Level of impairment: Mild Moderate Severe Profound I.Q.: _____ (must specify)

7. IMPAIRMENT RELATED CONDITION

- | | | |
|---|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cardiac/COPD | <input type="checkbox"/> Neuropathy | |
| <input type="checkbox"/> Respiratory | | _____ |

8. D E S C R I B E I N D E T A I L T H E A P P L I C A N T ' S P R I M A R Y D I S A B I L I T Y: (B E S P E C I F I C):

9. IS THIS DISABILITY:

- Permanent
- Temporary: This is to certify that the applicant stated within is a person with a temporary disability (six months or less) that limits or impairs his/her ability to walk or is temporarily sight impaired.

Date of Disability: _____ **through recovery date of** _____

Is this disability controlled by medication? Yes No

Explain:

Please attach any pertinent medical documentation (Test Results, Notes, Reports, etc.) that would help to explain the diagnosis or limitations on the applicant's ability to utilize Palm Tran's mass transit system.

WARNING: any person who knowingly makes a false or misleading statement in an application or certification may be denied eligibility to Paratransit services.

Print/Type Name of Certifying Authority Signature Date Signed

Business Street Address Number (Area Code) Telephone Number Fax

City State Zip Code

Certification or License No. **(REQUIRED)** _____

LICENSED IN THE STATE OF: _____

ENGLISH RECERTIFICATION



50 South Military Trail, Suite 101
West Palm Beach, Florida 33415



**Palm Beach County
Board of County Commissioners**

County Administrator
Verdenia C. Baker

