TRI-COUNTY COMMUNITY COUNCIL, INC.

Transportation Disadvantaged Application

Section 1: General Applicant Information			
First Name		**Middle Initial:**	**Last Name:**
Date of Birth (Age)	**Sex:** ☐ Male ☐ Female	**Telephone #:**	**Email:**
Street Address:		**Apt #:**	**Bldg #:**
City:		**State:**	**Zip Code:**
Building/Complex Name:		**Gate Code if Required:**	

Emergency Contact:		
First Name:		**Last Name:**
Telephone #:	**Relationship:**	**Email:**

Part A: What type of residence/facility do you live in?

☐ House ☐ Apartment ☐ Mobile Home ☐ Nursing Home/ REHAB Center

☐ Assisted Living ☐ Group Home ☐ Other ☐ : _____

Part B: Does your residence/facility have a ramp? ☐ Yes ☐ No

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

☐ Cane ☐ Crutches ☐ Leg Braces ☐ Walker

☐ Portable Oxygen ☐ Service Animal ☐ Sighted Guide ☐ White Cane (blind)

☐ Picture Board ☐ Alphabet Board ☐ Stretcher ☐ Wheelchair

☐ Powered Wheelchair ☐ Powered Scooter/Cart ☐ Lift Service ☐ Other (please specify)

Please Indicate the reason why you are seeking TD eligibility (check all that apply)

☐ I am age 60 or older or 17 or younger

☐ My income level falls below current federal poverty guidelines of 150% (Proof of income is required)

☐ I have a disability

☐ Other (please specify):

If applicant meets age criteria, fill out Section 1 only. Proceed to Applicant Signature on page two.

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Section 2: Verification of Income (Proof of Income is required unless age or disability criteria is met)

Part A: To determine if you qualify for Transportation Disadvantaged Services, please answer the following questions :

Number of people in household:	Total annual individual income:	Total annual household income:
_____	$ _____	$ _____

Part B: How many vehicles are owned/used by members in your household?

Part C: Are these vehicles available for use? ☐ Yes ☐ No

If not, please explain why:

Please submit one of the following proof of income with completed application :

- **First (1st) page of your Tax Return**
- **Department of Children and Families Benefit letter**
- **Minimum of two (2 Pay Check Stubs)**
- **HUD/ Section 8 Letter**
- **Social Security Income Verification**
- **Retirement/ Pension Statement**
- **Unemployment Compensation Income Verification**
- **CSBG/LIHEAP Letter**

Applicant Certification

I certify the information provided in this application is true and correct. 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. I authorize the medical professional(s) listed to release information to Tri-County Community Council, Inc. about my disability and its effects on my ability to travel. I understand that I may revoke this authorization at any time with written notice to Tri-County Community Council, Inc.

Applicant Signature: _____ **Date:** _____

DO NOT WRITE IN THIS SPACE – OFFICAL USE ONLY

New Eligibility Application: Yes / No **Redetermination: Yes / No** **Date Received:** _____

Reviewed by: _____ **PCA/Escort Needed: Yes / No**

Date Approved or Denied: _____

Reason for Denial: _____

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Section 3 : Medical Verification or Disability

This form must be completed by a medical professional if you are applying for Transportation Disadvantaged (TD) Service due to a medically verified physical or cognitive condition, impairment, or disability.

Acceptable Medical Professional Include:

Medical Doctor	**Audiologist**	**Physical Therapist**
Advanced Registered Nurse Practitioner	**Ophthalmologist**	**Occupational Therapist**
Physician Assistant (PA)	**Psychologist**	**Doctor of Osteopathic Medicine**
Registered Nurse / Licensed Practical Nurse	**Doctor of Chiropractic**	**Designated Staff**

Dear Medical Professional:

In order to process this applicant's request for Tri-County Community Council, Inc. service eligibility, we require this form be completed. Only licensed medical professionals or designee having knowledge of the applicant's functional ability to use Tri-County Community Council, Inc. services should complete this form.

Many of our vehicles are wheelchair accessible and equipped with wheelchair lifts/ramps. Therefore, use of a wheelchair does not automatically make an applicant eligible to use Tri-County Community Council, Inc. services.

Thank you for your assistance.

Applicant Name:	**Date of Birth:**
Part A: Has this person been diagnosed with a cognitive, mental, physical, or other disability requiring use of Tri-County Community Council, Inc. service ☐ Yes ☐ No	
Part B: Is the disability ☐ Permanent ☐ Temporary If temporary, how long?	

Medical Professional – Information		
Medical Professional's Name and Title:		
State of Florida License Number:	**Email:**	
Business Address:	**Suite #:**	**Bldg #:**
City:	**State:**	**Zip Code:**

Medical Certification

In signing, I acknowledge that, to the best of my knowledge, the information in the evaluation form is true and correct. I understand that providing false or misleading information could result in the re-examination of the eligibility status of the applicant as well as prosecution to the maximum extend allowed by the laws of the State of Florida.

Medical Professional's Signature: _____ Date: _____