



**TRI-COUNTY COMMUNITY COUNCIL, INC.**

**Transportation Disadvantaged Application**

<b>Section 1: General Applicant Information</b>			
First Name		Middle Initial:	Last Name:
Date of Birth (Age)	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone #:	Email:
Street Address:		Apt #:	Bldg #:
City:		State:	Zip Code:
Building/Complex Name:		Gate Code if Required:	

<b>Emergency Contact:</b>		
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.***



**TRI-COUNTY COMMUNITY COUNCIL, INC.**

**Transportation Disadvantaged Application**

**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 (1<sup>st</sup>) 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: \_\_\_\_\_



**TRI-COUNTY COMMUNITY COUNCIL, INC.**  
**Transportation Disadvantaged Application**

**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		<input type="checkbox"/> Yes <input type="checkbox"/> No
Part B: Is the disability		<input type="checkbox"/> Permanent <input type="checkbox"/> 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: \_\_\_\_\_