_____

Applicant Name

LAKE COUNTY CONNECTION
Application for ADA Services

Instructions to Applicant or Proxy:

1. Please be sure to print and complete all information requested and sign where indicated.
2. The Medical Verification section must be completed and signed by an approved health care professional. In some instances, this requirement may be waived based on a functional assessment conducted by staff. All provided information will be verified and confirmed. You may attach supporting documentation.
3. Completing this application does not automatically certify you for ADA services. Applicants may be required to go through a functional assessment to assist us in determining your level of eligibility. All applicants will be notified of the outcome of their application.

If you would like to be notified by e-mail, please check this box. ☐

WHEN COMPLETED, PLEASE RETURN THIS FORM TO:

Lake County Connection
P.O. Box 491597
Leesburg, FL 34749

Telephone: (352) 326-2278
Fax No. (352) 365-2982
E-mail: lccert@ride-right.net

OFFICE USE ONLY

Date Received: _____ **New Application:** ☐ **Approved** ☐ **Date:** _____

Recertification: ☐ **Denied** ☐ **Date:** _____

Reason for Denial: _____

_____

Reviewed By: _____ **Funding Source: ADA** ☐

Applicant Notified By: _____ **Date:** _____

Method Used to Notify Applicant: Telephone ☐ **Mail** ☐

E-mail ☐ **Other** ☐ _____

_____/_____/_____

Last Name First Name Middle Initial M/F Date of Birth

_____

Physical Address Apt./Lot No. City State Zip Code

_____

Complex/Subdivision/Facility Name Nearest Intersecting Street Nearest Bus Route

If this is a gated community, please provide gate code. _____

_____

Mailing Address Apt./Lot No. City State Zip Code

_____

Home Phone Work Phone Cell Phone E-mail Address

In case of emergency, please contact:

_____

Name Relationship to You Home Phone Cell Phone Work Phone

If we are unable to reach the Primary Emergency Contact listed above, please provide a secondary emergency contact.

_____

Name Relationship to You Home Phone Cell Phone Work Phone

Please check all that apply to you.

___ Portable Oxygen ___ Assisted Walking ___ Need Escort ___ Wheelchair

___ Visually Impaired ___ Cane ___ Crutches ___ Walker

___ Service Animal ___ Stretcher ___ Mental Impairment ___ Hearing Impaired

---

<u>Functional Ability</u>

Without the assistance of someone else, can you:

Board a bus?	Yes ___	No ___	Read/understand directions?	Yes ___	No ___
Handle coins and bus transfers?	Yes ___	No ___	Travel on a sidewalk?	Yes ___	No ___
Travel to the nearest bus stop?	Yes ___	No ___	Stand at a bus stop?	Yes ___	No ___
Identify the correct bus?	Yes ___	No ___	Walk ¾ mile?	Yes ___	No ___
Climb a 12 inch step?	Yes ___	No ___	Cross a street?	Yes ___	No ___
Balance yourself while seated?	Yes ___	No ___	Grip handles and railings?	Yes ___	No ___
Give your address and phone number?	Yes ___	No ___	Recognize landmarks?	Yes ___	No ___
Wait outside for more than 15 minutes?	Yes ___	No ___	Travel through crowds?	Yes ___	No ___

Are you able to travel alone? ___ Yes ___ No

Do you currently use LakeXpress service? ___ Yes ___ No

(All buses are fully accessible with wheelchair lifts and many can kneel for easy access.)

If you do not use the LakeXpress service, please read the following statements and check those which apply to you. You may select more than one.

☐ I have a temporary disability which prevents me from getting to the bus stop or using the service. I will need ADA service only until I recover.

☐ I cannot get to the bus stop.

☐ I have a cognitive disability which prevents me from remembering and understanding all I have to do to find my way to and from the bus stop and to ride the bus.

☐ I have a visual disability which prevents me from finding my way to and from the bus stop.

☐ I have a severe medical condition. My conditions results in an impairment which makes it impossible for me to use regular bus service.

☐ I have an episodic disability. I can use the bus on those days when I am feeling well, but on bad days, I can't make it to the bus stop, or even get on the bus.

Certification and Acknowledgement

I understand and affirm that the information provided in this application for ADA transportation services is true and correct to the best of my knowledge and will be kept confidential and shared only with medical and transportation professionals involved in evaluating and determining my needs and eligibility for transportation to and from eligible services as well as appointments.

I understand that providing false or misleading information or making fraudulent claims or making false statements on behalf of others could constitute a felony under the laws of the State of Florida and could result in my eligibility status being revoked. I agree to notify Lake County Connection if there is any change in circumstances or I no longer need to use ADA services. I understand if I am approved for the ADA Program I must be recertified two years from the date of approval for services.

Lake County Board of County Commissioners and our Operator, Ride Right, LLC collects your social security number, if applicable, for the following purposes:

Identification and verification
Billing and payments
Benefit processing

Social security numbers may be used as a unique numeric identifier and may be used for search purposes.

_____

Applicant's Signature Date

_____

Signing for Applicant Relationship Date

Applicant's Release

I understand that the purpose of this evaluation form is to determine my eligibility for paratransit service. 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. I hereby authorize my medical representative to release any and all information regarding my medical condition to Lake County Connection. I understand that providing false or misleading information could result in my eligibility status being revoked. I agree to notify Lake County Connection within 10 days if there is any change in circumstances or I no longer need to use ADA services.

_____

Applicant's 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

MEDICAL VERIFICATION – To be completed by a licensed 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.

What is the applicant's disability? _____

_____

_____

How does the condition functionally prevent the applicant from using regular bus service?

_____

_____

_____

Is this condition permanent or temporary? Permanent ____ Temporary ____

If temporary, what is the duration? _____

Signature of Medical Professional _____ Date _____

Professional License Number _____ State Issued _____

Print Name _____

Address _____

City _____ State_____ Zip Code _____

Phone Number _____ Extension _____

Contact Person _____