ID#_____

STS Application

SPECIAL TRANSPORTATION SERVICES (STS) APPLICATION FORM
MIAMI- DADE TRANSIT

I. APPLICATION SECTION:

S.S.# (9 digits)_____-_____-_____ Date of Birth:____/____/____ Sex: [ ] Male [ ] Female

Last Name:_____ First Name_____ M.I.:_____

Street Address: _____ Apt.#: _____ City:_____ State: _____

Zip Code: _____ Home Phone:( ) _____ Email address: _____

Is this a [ ] House [ ] Apartment [ ] Nursing Home [ ] ACLF [ ] Boarding Home

Applicant's weight: _____ lbs. Wheelchair (if applicable) weight _____ lbs. length _____, width_____

EMERGENCY CONTACT: Name and telephone number of someone we can call in an emergency.

Name:_____ Relationship:_____ Phone: ( )_____

ETHNICITY: (*for statistics only, optional)*
[ ] White Non-Hispanic [ ] Black Non-Hispanic [ ] Hispanic [ ] Other *(specify)*_____

A. If you use a wheelchair, can you transfer with minimal assistance into a sedan? Y___ N ___
Type of wheelchair: [ ] Manual [ ] Motorized [ ] Scooter *(Three wheeled)*
B. If someone assisted the client to complete this form, please specify;

Name: _____Relationship: _____ Phone: ( ) _____
If you need to have information given to you in an accessible format, please check one:
[ ] Braille [ ] Large Print [ ] Audio [ ] Computer Disk (ASCII) or CD

II. APPLICANT'S RELEASE:

The following information is requested to determine when an under what circumstances the applicant can use the County bus, rail, or mover service and when Special Transportation Service (STS), van/sedan shared-ride paratransit service, is required.

I understand that the purpose of this form is to determine if I am eligible for Miami-Dade Transit Agency's (MDT) Special Transportation Service (STS) in accordance with the American with Disabilities Act (ADA) of 1990 complementary paratransit service requirement. 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 certify that, to the best of my knowledge, the information in this form is true and correct. I understand that providing false or misleading information could result in my eligibility status being re-examined as well as prosecution to the maximum extend allowed by the laws of the State of Florida. I hereby authorize my medical representative to release any and all information required by the MDT Paratransit Certification Enrollment Office regarding my medical condition for the purpose of determining my eligibility to use Special Transportation Service (STS).

Applicant's Signature: _____ Date: _____

If applicant is unable to sign this form, he/she may have someone sign and certify on applicant's behalf.

Signing for applicant: _____ Date: _____

Print Name: _____ Relationship to applicant:_____

III. MEDICAL VERIFICATION (*to be completed by a Florida licensed physician)*

The Americans with Disabilities Act of 1990 (ADA) requires all public entities operating fixed- route transportation service for the general public to also provide complementary paratransit service to persons unable to use the fixed-route system. Miami-Dade Transit (MDT), Special Transportation Service (STS) provides complementary paratransit shared ride (i.e. van/sedan) service to individuals certified as ADA paratransit eligible. The applicant who has asked you to review and sign this form is applying to MDT to be considered eligible for this service. This application form will assist MDT to determine when and under what circumstances the applicant can use Metrobus, Metrorail, or Metromover service and when they require paratransit service. ADA/STS van/sedan shared-ride service is intended only for those trips that the person cannot make on the bus/rail/mover system.

STS ELIGIBILITY CRITERIA:

Applicants shall be individually evaluated, and eligibility shall be determined based on a functional ability to use conventional public transportation: Metrobus, Metrorail, and Metromover. Functional inability to use public transportation includes the Americans with Disabilities Act (ADA) Categories 1, 2 and 3 as described in this application.

A. AMERICANS WITH DISABILITIES ACT (ADA) CATEGORIES:

Check the categories of eligibility that you recommend should apply.

1. [ ] The individual is unable, as a result of a physical or mental impairment (*including a vision impairment),* and without the assistance of another individual, *(except the operator of a wheelchair lift or other boarding device),* to board, ride, or disembark from an accessible bus or rail vehicle.

2. [ ] The individual needs the assistance of a wheelchair lift or other boarding assistance device and is able, with such assistance, to board, ride, and disembark from accessible transit vehicles. *(The individual would be eligible if an accessible vehicle is not available.)*

3. [ ] The individual has a specific impairment-related condition which prevents the individual from traveling to or from: Metrobus; Metrorail; and/or Metromover stops/stations.

4. [ ] Check here, if none of these categories apply.

MEDICAL REPRESENTATIVE'S LETTERHEAD OR PRESCRIPTION FORM REQUIREMENT:

In order to process this applicant's request to become a qualified STS rider, we require that the medical certification section of this form be completed, and a letterhead or prescription form with the name and address of both the medical representative and the applicant be attached to this application. To expedite applicant processing, please attach objective medical findings which substantiate the disability. Examples include:

EEG or Neuropsychological Evaluation with FSIQ
Snellen (visual acuity) and/or Perimeter Chart (field of vision) Report(s)
Elisa Western Blot result reading CD4 + counts
X-ray, MRI, or CAT Scan Findings
Respiratory FVC/FEV1

III. MEDICAL VERIFICATION *(To be completed by a licensed physician)*

B. INDICATE THE TYPE AND NATURE OF THE INDIVIDUAL'S DISABILITIES).

CHECK AS MANY ITEMS AS MAY BE APPLICABLE. *(SEE STS ELIGIBILITY CRITERIA)*

1. MOBILITY IMPAIRMENT:

a. [ ] Non-ambulatory disability *(required wheelchair to travel).* Please specify the condition which requires full time use of a wheelchair_____

b. [ ] 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).

I. Amputation *(detail extremity):*_____

II. [ ] Stroke without Hemiplegia III. [ ] Stroke with Hemiplegia IV. [ ] Brain Spinal Nerve Trauma

V. [ ] Other: _____

Date disability started: _____ (Please attach EEG or neuropsychological evaluation report)

2. NEUROLOGICAL DISABILITY *(motor dysfunction):*

(Please attach EEG or neuropsychological evaluation report)

a. [ ] Multiple Sclerosis b. [ ] Epilepsy c. [ ] Muscular Dystrophy d. [ ] Cerebral Palsy

e. [ ] Parkinson's f. [ ] Alzheimer's g. [ ] Other_____

3. VISUAL DISABILITY:

a. [ ] Totally blind

b. [ ] Legally blind - If this person is legally blind 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 both eyes)

4. COGNITIVE DISABILITY:

a. Type of mental impairment:

[ ] Emotional [ ] Autism [ ] Cognitive Disability [ ] Dementia

[ ] OBS [ ] Alzheimer's [ ] Development Disability [ ] Other

(Please attach EEG or neuropsychological evaluation showing full scale intelligent quotient "FSIQ" or mental age, as applicable.)

b. Level of mental impairment: [ ] Mild [ ] Moderate [ ] Severe [ ] Profound, I.Q.:_____

(Must Specify)

5. UNCONTROLLED FATIGUE:

a. [ ] Radiation/Chemo b. [ ] Dialysis If either a. or b. is marked please provide the following:

Treatment Schedule (or duration): _____ Treatment Start and expected End date: _____thru _____

Treatment Center: _____ Address:_____

c. [ ] HIV (Please attach Elisa, Western Blot result reading CD4 + counts.) d. [ ] Other_____

6. IMPAIRMENT RELATED CONDITION:

a.[ ] Arthritis (Please attach MRI/CA T/X – ray findings or operative reports of area affected)
{Functional Classification ____ Anatomical Stage _____} b. [ ] Other _____

b.[ ] Cardiac (Please attached EKG or operative findings)
{Functional Classification _____ Therapeutic Classification _____ }

c. [ ] Respiratory *(Must Specify)* {FVC _____ FEV1 ____ } (Please attach oxymetric capability report)

C. DESCRIBE IN DETAIL THE APPLICANT'S PRIMARY DISABILITY: (BE SPECIFIC)

_____

_____

_____

D. IS THIS DISABILITY: [ ] Permanent [ ] Temporary (If temporary, date of disability _____ &length of recovery_____)

E. IS THIS DISABILITY CONTROLLED BY MEDICATION? [ ] Yes [ ] No

Explain: _____

_____

_____

F. INDICATE THE TASKS RELATED TO USING PUBLIC TRANSIT THAT THE APPLICANT WOULD FIND IMPOSSIBLE (NOT DIFFICULT) TO DO. CHECK ALL THAT APPLY

[ ] No limitations that would prevent the use of bus/rail service
[ ] Boarding vehicle without a wheelchair lift
[ ] Enduring common weather conditions
[ ] Identifying a public transit vehicle
[ ] Understanding/handling bus fare *(money)* transactions
[ ] Handling changes in normal routine
[ ] Walking more than _____ blocks *(Must stipulate number of blocks)*
[ ] Enduring warm weather
[ ] Waiting thirty minutes
[ ] Recognizing a bus stop
[ ] Recognizing destinations if stops are announced
[ ] Climbing 1-3 Steps

These limitations apply: [ ] Always [ ] Usually [ ] Occasionally [ ] Rarely

G. MOBILITY AID: [ ] Wheelchair [ ] Walker [ ] Crutches [ ] Braces [ ] Service Animal
[ ] None [ ] Cane [ ] Other _____

H. REQUIRED MODE OF TRANSPORTATION: Please indicate the type of transportation required by the applicant based on his/her functional ability.
[ ] Ambulatory (van, sedan) [ ] Wheelchair Transferable (van, sedan) [ ] Wheelchair Confined (lift van)

I. BASED ON THE INDIVIDUAL'S DISABILITY, DO YOU RECOMMEND HIM/HER TO BRING A PERSONAL CARE ATTENDANT ON EACH TRIP? [ ] Yes [ ] No

J. PLEASE ATTACH PERTINENT MEDICAL DOCUMENTATION (E.G. EVALUATIONS, TEST RESULTS, NOTES, REPORTS, ETC.) THAT WOULD HELP TO EXPLAIN THE DIAGNOSIS OR LIMITATIONS ON THE APPLICANT'S ABILITY TO USE METROBUS, METRORAIL, OR METROMOVER.

NOTE: Failure to attach documentation will delay the eligibility determination process and will require that MDT contact your office to obtain pertinent documentation before rendering a decision.

IN SIGNING, I ACKNOWLEDGE THAT, TO THE BEST OF MY KNOWLEDGE, THE INFORMATION IN THIS EVALUATION FORM IS TRUE AND CORRECT. FURTHERMORE, I CERTIFY THAT, I HAVE ATTACHED OBJECTIVE MEDICAL TESTS/DOCUMENTATION WHICH SUBSTANTIATES THE ABOVE STATEMENTS. I UNDERSTAND THAT PROVIDING FALSE OR MISLEADING INFORMATION COULD RESUT IN THE RE-EXAMINATION OF THE ELIGIBILITY STATUS OF THE APPLICANT AS WELL AS PROSECUTION TO THE MAXIMUM EXTENT ALLOWED BY THE LAWS OF THE STATE OF FLORIDA.

[ ] Yes, I have attached the required medical documentation

_____	_____	_____
Print or Type Name of Physician	**State of Florida License #**	**Signature**

_____	_____	(_)_____	(____)_____
Office Address	**City State Zip Code**	**Telephone**	**Fax #**

MIAMI-DADE COUNTY
TRANSIT

"Por favor, para informacion en español llame al (786) 786-469-5000, Gracias"
"Sil vou ple, an creole, rele pou informasyon numero (786) 469-5000, Merci"

Dear Applicant:

This package was prepared and sent to you in response to your request for an application for the Miami-Dade Transit (MDT) Special Transportation Services (STS) which is our Americans with Disabilities Act (ADA) paratransit service. A copy of our "ADA Paratransit Application Form" is attached for your convenience. Please read this letter and the enclosed material carefully before attempting to complete this application. Information about your disability which you provide in the application will be kept strictly confidential.

Copies of this form are available in large print, Braille, cassette and CD upon request. If you have questions or need assistance completing this form, call MDT at:

(786) 469-5000 (305) 263-5459 TTY/TDD

"ADA Paratransit" service is a van/sedan shared-ride service, comparable to standard fixed route transportation (Metrobus/Metrorail/Metromover) services. This service is provided to individuals who, because of a functional disability, are prevented from using the fixed route transportation service. This might include not being able to get to or from bus stops, not being able to get on or off buses, or not being able to understand (due to a cognitive or development disability) how to ride and use the fixed route service. MDT has made a number of changes and improvements to the county fixed route public transportation system to make it more accessible to persons with disabilities. All Metrorail and Metromover stations have ramps and elevators and other accessibility features.

MDT will provide van/sedan shared-ride to persons determined to be "ADA Paratransit Eligible" for those trips that cannot be made using the county fixed route transportation service. You may, for example, be able to use county bus service for some trips there are no barriers which prevent you from getting to and from the bus stop. At other times, you might not be able to use the bus because it is not lift-equipped or there is a barrier which prevents access to the bus stop. ADA Paratransit van/sedan service is meant to assist you at these times.

There are two types of ADA Paratransit eligibility:

- Unconditional – this eligibility is granted if your disability prevents you from using county fixed route transportation service for any trip that you might need to make.
- Conditional – this eligibility is granted if you can use the county fixed route transportation service under certain circumstances, but need paratransit service for other trips.

To enable us to accurately determine your eligibility for this service, please complete the enclosed application form and be as thorough as possible. It is important that all sections of the application form are completed. <u>If any sections are left blanks, the form will not be accepted.</u>

Once the application is completed, mail this application to MDT- Paratransit Operations, 701 NW 1st Court, Suite 1100, Miami, Florida 33136 as part of the ADA paratransit eligibility certification process. (See page II for details).

Completed applications will be processed within 21 days of receipt. You will be notified by letter of your eligibility determination for ADA paratransit service. If you have not heard from us within 21 days, please call and we will provide you with paratransit services until your application is processed. Please note that in some instances, we may not be able to determine your eligibility without further information. In this case we may request further documentation from your medical representative.

If you are determined to be eligible for ADA paratransit service (either unconditionally or conditionally), an "STS Rider's Guide", which provides information about the service and how to use it will be sent to you along with an approval letter and a picture ID card.

If it is determined that you are able to use county fixed route transportation service and therefore are nor eligible for paratransit service, we will notify you in writing of the reason(s) for this determination. An opportunity to appeal this decision in person will also be provided to you.

MDT's is to continue to work to provide reliable and accessible transportation to everyone who needs it. We have made a number of improvements to the county fixed route transportation system and offer many personalized services to assist individuals to use it.

<u>INSTRUCTIONS FOR COMPLETING THIS FORM:</u>

The applicant (or an assistant) must complete Parts I and II. A licensed physician must complete and sign the MEDICAL VERIFICATION PART III. Once you have this form completed and signed by your medical representative, please MAIL THIS APPLICATION to MDT – Paratransit Operations, 701 NW 1st Court, Suite 1100, Miami, Florida 33136.

If you have no other means of transportation, STS transportation will be provided to you to attend the in-person assessment. The STS fare is a flat rate of $3.00 per one-way-trip and will be charged each way both to you and to any companion attending with you.

If you are determined eligible for ADA paratransit service (either unconditionally or conditionally) at the time of your in-person assessment, you will be provided with an STS Rider's Guide and an I.D. card. An approval letter will be sent by mail at a later date.

Please note that in some instances, we may not be able to determine your eligibility without further information. It is recommended that you obtain, from your medical representative, objective medical documentation which can substantiate your medical condition(s) and provide insight regarding your functional abilities or limitations when using the fixed route transportation system. If medical documentation is not attached to the applicant or if determined necessary, we may request further documentation from your medical representative before a determination is made. You will receive notification by mail of our final determination.

ALL QUESTIONS MUST BE ANSWERED. INCOMPLETE AND/OR UNSIGNED FORMS WILL NOT BE ACCEPTED AND MAY CAUSE A DELAY IN YOUR ELIGIBILITY DETERMINATION.

Miami-Dade Transit will process your application. As part of your processing, you may be required to attend an in-person interview.