**Recertification Application**

*Revised Jan, 2017*

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

**Programs that may require recertification at this time**

**Americans with Disabilities Act (ADA)**

**AND/OR**

**Transportation Disadvantaged (TD)**

**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 one or more of the programs 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.
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?

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>TIME OF SERVICE</th>
<th>HOLIDAY HOURS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Americans with Disabilities Act (ADA)</td>
<td>Monday to Friday 5:00 am to 10:10 pm</td>
<td>NO SERVICE ON THE FOLLOWING DAYS</td>
</tr>
<tr>
<td></td>
<td>First pick-up no earlier than 5:00 am to 5:30 am</td>
<td>New Year's Day</td>
</tr>
<tr>
<td></td>
<td>Last pick-up no later than 9:00 pm to 9:30 pm</td>
<td>Easter Sunday</td>
</tr>
<tr>
<td>Transportation Disadvantaged (TD)</td>
<td>Saturday 6:00 am to 10:10 pm</td>
<td>Memorial Day</td>
</tr>
<tr>
<td></td>
<td>First pick-up no earlier than 6:00 am to 6:30 am</td>
<td>Independence Day</td>
</tr>
<tr>
<td></td>
<td>Last pick-up no later than 9:00 pm to 9:30 pm</td>
<td>Labor Day</td>
</tr>
<tr>
<td></td>
<td>Sunday 8:00 am to 6:00 pm</td>
<td>Thanksgiving Day</td>
</tr>
<tr>
<td></td>
<td>First pick-up no earlier than 8:00 am to 8:30 am</td>
<td>Christmas Day</td>
</tr>
<tr>
<td></td>
<td>Last pick-up no later than 5:00 pm to 5:30 pm</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>PLEASE NOTE TIME MAY VARY BASED ON DISTANCE</strong></td>
<td></td>
</tr>
<tr>
<td>Division of Senior Services (DOSS)</td>
<td>Monday thru Friday 8:00 am to 5:00 pm</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No Service on Saturday &amp; Sunday</td>
<td></td>
</tr>
</tbody>
</table>

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 Saturday from 7:00 am to 5:00 pm and 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.
PART 1. GENERAL INFORMATION

Please Print

Last Name: _____________________________First Name: _____________________________

Street Address: ___________________________ Apt#: _______ Bldg#: _______

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:

<table>
<thead>
<tr>
<th>Contact Name/Relationship/Address</th>
<th>Contact Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

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 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

To register for the Special Care Unit, please contact the Palm Beach County Emergency Operations Center at (561) 712-6400.
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.)
   - Rider cannot be left unattended
   - 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)? Please note that we may require you to travel with a PCA if your condition or disability is severe.

   ○ No  ○ Always  ○ Sometimes

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.

<table>
<thead>
<tr>
<th>Name of Applicant as printed on the Identification</th>
<th>Signature of Applicant, Parent or Guardian of Applicant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth</td>
<td>Sex</td>
</tr>
<tr>
<td></td>
<td>Date Signed</td>
</tr>
<tr>
<td>Street Address</td>
<td>City</td>
</tr>
<tr>
<td></td>
<td>State</td>
</tr>
<tr>
<td></td>
<td>Zip Code</td>
</tr>
</tbody>
</table>

**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**  
   [ ] Standard Wheelchair  [ ] Cane  [ ] Other:__________________________
   [ ] Wide Wheelchair  [ ] Walker  [ ] Crutches
   [ ] Scooter  [ ] Braces
   [ ] Wide Scooter  [ ] Service Animal

3. **NEUROLOGICAL DISABILITY (MOTOR DYSFUNCTION):**  
   [ ] Multiple Sclerosis  [ ] Epilepsy  [ ] Other:__________________________
   [ ] Muscular dystrophy  [ ] Alzheimer’s
   [ ] Cerebral Palsy  [ ] 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
6. **COGNITIVE OR SENSORY IMPAIRMENT:**

<table>
<thead>
<tr>
<th>[ ] Autism</th>
<th>[ ] Dementia</th>
<th>[ ] Other:__________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Down Syndrome</td>
<td>[ ] Alzheimer’s</td>
<td></td>
</tr>
<tr>
<td>[ ] Developmental Disability</td>
<td>[ ] Emotional</td>
<td></td>
</tr>
</tbody>
</table>

Level of impairment: [ ] Mild   [ ] Moderate   [ ] Severe   [ ] Profound  I.Q.:__________ (must specify)

7. **IMPAIRMENT RELATED CONDITION**

<table>
<thead>
<tr>
<th>[ ] Hearing Impaired</th>
<th>[ ] Arthritis</th>
<th>[ ] Other:__________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Cardiac/COPD</td>
<td>[ ] Neuropathy</td>
<td></td>
</tr>
<tr>
<td>[ ] Respiratory</td>
<td></td>
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</tbody>
</table>

8. **DESCRIBE IN DETAIL THE APPLICANT’S PRINCIPAL DISABILITY: (BE SPECIFIC):**

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.

10. **PERSONAL CARE ATTENDANT:**

[ ] Applicant requires a personal care attendant and cannot travel alone.

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

<table>
<thead>
<tr>
<th>Print/Type Name of Certifying Authority</th>
<th>Signature</th>
<th>Date Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Street Address Number</td>
<td>(Area Code) Telephone Number</td>
<td>Fax</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
</tr>
</tbody>
</table>

Certification or License No. (REQUIRED) ___________________________ of a Physician, Osteopathic or Podiatric Physician, Chiropractor, Optometrist, Advanced Registered Nurse Practitioner under the protocol of a licensed physician or a Physician Assistant licensed under Chapter 458 or 459.

**LICENSED IN THE STATE OF:** ___________________________
RETURN COMPLETED
RECERTIFICATION WITHIN 30 DAYS TO
AVOID SERVICE EXPIRATION