Dear TOPS! Applicant:

Thank you for your interest in TOPS! The Florida Commission for Transportation Disadvantaged (TD) program is one of the transportation programs provided by TOPS! The TD program is for individuals who are prohibited from using the Broward County Transit (BCT) fixed-route bus service due to financial limitations or require door-to-door service due to physical and/or mental disabilities.

The TD program provides two types of service:

1. **Bus Pass Program** – A monthly BCT fixed-route bus pass is provided at no charge to qualifying individuals who are financially prohibited from using the fixed-route system.

2. **Door-to-Door Paratransit Transportation** – Shared-ride paratransit transportation is provided to qualifying individuals who are prohibited from using the BCT fixed-route bus system due financial, physical and/or mental restrictions. Door-to-door paratransit transportation will be provided to health care, employment, education, shopping, social activities, other life-sustaining activities or children who are handicapped, high-risk or at-risk.

ELIGIBILITY: Both services require the applicant to qualify under the current Federal Poverty Level guideline, depending on the number in the household, at the 100 percent level.

Complete the TD program application for either service. The completed TD application must contain all requested information, be legible and have all required identification and applicable financial supporting documents included when submitted. Door-to-door Paratransit applications must also have the medical information (Section 3) completed and signed by a Florida licensed physician.

Return to: Paratransit Eligibility Services
Broward County Transit
1 N. University Dr., Suite 3100-A
Plantation, FL 33324.

NOTICE OF COLLECTING SOCIAL SECURITY NUMBER (SSN) FOR GOVERNMENT PURPOSE
Broward County collects SSNs for different purposes. The Florida Public Records Law, Section 119.071(5), F.S. (2007) requires the County to give you this written statement explaining the purpose and authority for collecting your SSN.

FORM	PURPOSE	AUTHORIZATION
TD Application	Conduct eligibility verification and monitor for system abuse	County policy (See Note)

NOTE: Broward County collects your SSN in the performance of a duty or responsibility the County must complete in accordance with law or business necessity. In the event a law does not specifically provide the County with the authority to collect your SSN, it is imperative that the County collect your SSN and this is expressly provided in section 119.081 (5) 2.b.

Transportation Disadvantaged Application
BUS PASS / PARATRANSIT SERVICE
Broward County Transit

INSTRUCTIONS:
Sections 1 and 2 must be completed to apply for either program**. Complete section 3 (Medical) ONLY if you are applying for door-to-door paratransit transportation.**

COPY OF CURRENT / VALID FLORIDA DRIVER'S LICENSE OR FLORIDA ID IS REQUIRED WITH APPLICATION

SECTION 1 – GENERAL INFORMATION (PLEASE PRINT)

Name of Applicant:	Phone:
Home Address:	
Mailing Address (if different):	
Is a vehicle registered in your name? YES ☐ NO ☐ Do you drive? YES ☐ NO ☐	
Date of Birth:	Social Security Number:
Emergency Contact:	Phone:
Medicaid Number (if applicable):	Medicaid Code(s):
Number of relatives, including self, living in household:	Total Annual Household Income (**Must total lines 1 through 8 below**):

Indicate the amount of annual income received by, or indicated on, each of the following sources for ALL members of household (list household members on reverse side):

1. Page #1 of individual tax return - $_____
2. DCF Benefit Letter - $_____
3. Unemployment Compensation Income Verification - - - - - - - - - - - - $_____
4. Social Security Income Statement or Proof of Income Letter (SSI / SSDI) - $_____
5. Retirement/Pension Statement (includes VA) - - - - - - - - - - - - - - - $_____
6. Supplemental Nutrition Assistance Program (SNAP) - Food Stamps - - $_____
7. Aid to Families with Dependent Children (AFDC) - - - - - - - - - - - - - $_____
8. Investment Income - $_____

If $0 income – You must submit signed letter, on agency letterhead, from a social service agency or similar organization, verifying there is no income.

COPY OF OFFICAL APPLICABLE DOCUMENT(S) FOR EACH ITEM(S) COMPLETED ABOVE, #1 THROUGH #8, MUST BE SUBMITTED WITH APPLICATION OR APPLICATION WILL NOT BE PROCESSED

(over)

SECTION 2 – HOUSEHOLD MEMBERS (PLEASE PRINT)

1. Name:	Date of Birth:
Medicaid Number (if applicable):	Social Security Number:
2. Name:	Date of Birth:
Medicaid Number (if applicable):	Social Security Number:
3. Name:	Date of Birth:
Medicaid Number (if Applicable):	Social Security Number:
4. Name:	Date of Birth:
Medicaid Number (if applicable)	Social Security Number:
5. Name:	Date of Birth:
Medicaid Number (if applicable):	Social Security number:
6. Name:	Date of Birth:
Medicaid Number (if applicable):	Social Security Number:
7. Name:	Date of Birth:
Medicaid Number (if applicable):	Social Security Number:
8. Name:	Date of Birth:
Medicaid Number (if applicable):	Social Security Number:

I attest that all information included on this application is correct and that any changes will be reported to Broward County Transit Paratransit Services immediately.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Preparer (if other than applicant) Date

_____ _____

Print Name (Preparer) Relationship

<u>Return to:</u> Broward County Transit - Paratransit Services Eligibility
1 N. University Dr. - 3100-A, Plantation, FL 33324

Transportation Disadvantaged Application
BUS PASS / PARATRANSIT SERVICE
Broward County Transit

APPLICANT NAME: _____ Date of Birth: _____

SECTION 3 – MEDICAL (TO BE COMPLETED BY HEALTH CARE PROVIDER) (PLEASE PRINT)

Does applicant have Medicaid? Y ☐ N ☐ If Yes, Medicaid # _____ Program Code: _____

Mobility Aides				Other		Treatments
Crutches	☐	Walker	☐	Oxygen	☐	Chemo ☐ Radiation ☐
Scooter	☐	Cane	☐	Hearing	☐	Dialysis ☐
PWR W/C	☐	AMBI	☐	Visual	☐	Day(s): _____
Leg Brace	☐	W/C	☐	Acuity	☐	Times: _____
Back Brace	☐	None	☐	Cognitive	☐	Facility Name: _____
						Facility Address: _____
						_____
						_____

Reason(s)/Condition(s) that prevent applicant from using fixed-route bus service:

Diagnostic Code(s) _____ Diagnosis_____
Explanation why this condition prohibits use of fixed-route bus: _____
_____
_____
_____

I, the undersigned, certify the medical information provided on this TD application is true and correct. I understand that providing false or misleading information constitutes fraud and is considered a felony under the laws of the State of Florida.

_____ _____
Doctor's Name (Print) FL Medical License Number

_____ _____
Doctor's Signature Telephone Number

INTERNAL USE ONLY – DO NOT WRITE BELOW THIS LINE

PIN#:_____			
Expires: _____	Round Trip Service ___	Miles to Ctr _____	Feet to Ctr _____
Processed by: _____	Return Trip Only ___	# of Closer Ctrs _____	Feet to BCT ____
Approved ____			Total Distance ____
Not Approved ____			Total # of BCT Buses Required ____
Incomplete ____			