DIAL-A-RIDE
850-833-9168

Public Transportation Application
For the TRANSPORTATION DISADVANTAGED

ELIGIBILITY: In order to determine if applicants meet the programs eligibility Transportation Disadvantage services, the applicant must meet the following criteria.

☐ **Applicants trip origin and destination is NOT serviced by Emerald Coast Rider (ECR) fixed regularly scheduled routes. (Upon requested, fixed routes can deviated up to ¾ of a mile**

Check ONE that applies to the applicant for Transportation Disadvantaged Assistance

- ☐ 17 and under or over 60 years of age – **ANSWER SECTIONS A and E**
- ☐ Low Income **ANSWER SECTIONS A, B & E**
- ☐ Mental or physical Disability- **ANSWER SECTIONS A, C & E**
- ☐ Physically handicapped child, high-risk or at-risk child **-Answer SECTIONS A, C, D and E**

SECTION A

Applicant Information

Last Name: _____ First Name: _____ M.I. ____
Address: _____
City: _____ ST: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Age: _____ Date of Birth: _____ /_____ /_____ Sex: M ___ F ___
Marital Status: _____ Email: _____
Medicaid ID # or Card Control #_____ (if applicable)

PLEASE ATTACH A COPY OF A VALID PHOTO IDENTIFICATION CARD. Valid ID Cards include a Driver License, State Identification Card or Passport. *** **IF YOU DO NOT SUMBIT A CLEAR VALID ID, THE APPLICATION IS VOID*****

1. Do you own or have access to a vehicle or other means or transportation?
   YES _____ NO _____

   If you answered 'yes' to No. 1, please explain why you or other household members are unable to transport you to medical and other appointments and trips.
   _____
   _____

2. Are you able to use the Fixed Route (Bus stop routes) service, if available, for your transportation needs?

   Yes _____ No _____

   If no, please explain why you aren't able to use available fixed route? _____

   _____
   _____

   _____

SECTION A

CONTINUED

Please List All Household Member Information that is applicable:

Name: _____ Relationship to Applicant _____ M ___ F ___
Birth Date ____ / ____ / _____ Medicaid ID or Card Control # _____

Name: _____ Relationship to Applicant _____ M ___ F ___
Birth Date ____ / ____ / _____ Medicaid ID or Card Control # _____

Name: _____ Relationship to Applicant _____ M ___ F ___
Birth Date ____ / ____ / _____ Medicaid ID or Card Control # _____

Name: _____ Relationship to Applicant _____ M ___ F ___
Birth Date ____ / ____ / _____ Medicaid ID or Card Control # _____

Emergency Contact:
Name: _____ Relationship: _____
Phone: _____

SECTION B

INCOME VERIFICATION

1. Is the applicant employed? Yes ____ No ____
2. If yes, list place of employment _____
   City: _____, ST _____
3. If married, is spouse employed? Yes ____ No _____
   If yes, list place of employment _____
   City: _____, ST _____
4. Does the applicant receive Florida Medicaid Insurance? Yes ____ No ____
   IF YES, PLEASE SUBMIT A COPY OF A VALID CARD
5. TOTAL Gross Monthly Household Income $ _____
6. TOTAL Number of Members in Household _____

IF APPLICANT IS FLORIDA MEDICAID RECIPIENT, ATTACH COPY OF VALID MEDICAID CARD. IF APPLICANT IS NOT A MEDICAID RECIPIENT, ATTACH COPIES OF TWO (2) RECENT CHECK STUBS FOR ALL EMPLOYED HOUSEHOLD MEMBERS

SECTION C

DISABILITY ELIGIBILITY

1. Is the applicant physically or mentally disabled? Yes ____ No ____
   If yes, does the applicant have Medicare or Florida Medicaid? Yes ____ No ____
   If yes, please submit a copy of the Medicare or Florida Medicaid card.

3. Is this application for a handicapped child? Yes ____ No ____
   If yes, does the child have Medicare or Florida Medicaid? Yes _____ No _____
   If yes, please submit a copy of the child's Medicare or Medicaid Card

IF THE APPLICANT IS DISABLED AND UNABLE TO RIDE FIXED ROUTE BUT DOES NOT HAVE MEDICARE OR FLORIDA MEDICAID, A MEDICAL VERIFICATION FORM SHOULD BE COMPLETED BY YOUR DOCTOR AND SUBMITTED FOR APPROVAL. PLEASE REQUEST FORM FROM EC RIDER OFFICE.

SECTION D

Other Eligible Criteria
AT-RISK or HIGH-RISK CHILD

"High-risk child" or "At-risk child" means a preschool with one or more of the following characteristics?

a) The child is a victim or a sibling of a victim in a confirmed or indicated report of child abuse or neglect.
b) The child is a graduate of a perinatal intensive care unit.
c) The child's mother is under 18, unless the mother received necessary comprehensive maternity care and the mother and child currently receive necessary support services.
d) The child has a developmental delay of one standard deviation below the mean in cognition, language or physical development.
e) The child has survived a catastrophic infectious or traumatic illness known to be associated with developmental delay.
f) The child has survived an accident resulting in a developmental delay.
g) The child has a parent or guardian who is developmentally disabled, severely emotionally disturbed, drug or alcohol dependent, or incarcerated and who requires assistance in meeting the child's developmental needs.
h) The child has no parent or guardian.
I) The child's family's is low income as defined by the CTC Local Coordinating Board (see Okaloosa County Transportation Development Service Plan [TDSP]).
j) The child is drug exposed.
k) The child is a pre-school handicapped child.
l) The child has been placed in residential care under the custody of the state through dependency proceedings.

CONTACT THE EMERALD COAST RIDER OFFICE IF THE APPLICANT MEETS ONE OF THE ELIGIBILITY CRITERION LISTED ABOVE.

SECTION E

SPECIAL NEEDS QUESTIONNAIRE.

TO ENSURE THE BEST SERVICE, PLEASE CHECK OR LIST ANY SPECIAL ACCOMMODATIONS YOU USE WHILE BEING TRANSPORTED:

NONE NEEDED _____ Cane _____ Service Animal _____ Companion Rider _____
Power Wheelchair _____ Walker ____ Respirator ____ Personal Care Assistant _____
Manual Wheelchair _____ Extra-Wide Wheelchair ____ Scooter ____
Stretcher_____ Other: _____

Certification and Acknowledgement

I understand and affirm that the information contained in this application for Transportation Disadvantaged financial and transportation assistance 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 of transportation to and from eligible services and appointments. I understand that providing false, incomplete or misleading information or making fraudulent claims or making false statements on behalf of others constitutes a felony under the laws of the State of Florida.

I also understand that Transportation Disadvantage costs depend on distance travelled and ***payment is due to the driver(cash or coupons only) as soon as I board the vehicle and cannot be billed****.* ***I also understand that trips are subject to availability and are NOT guaranteed.***

Applicant Signature _____ **Date:** _____ / _____ / _____

If Applicant is unable to sign,
Signature of Authorized personnel/Title _____ **Date:** _____/_____/_____

If Applicant is under 18,
Signature of Parent/Guardian _____ **Date:** _____/_____/_____

PLEASE RETURN COMPLETED APPLICATION ALONG WITH COPIES OF ELIGIBILITY QUALIFYING DOCUMENTS TO:

ATTN: TRANSPORTATION DISADVANTAGED
600 TRANSIT WAY
FORT WALTON BEACH, FL 32547
Phone: (850) 833-9168
TDD (850) 833-9283
Email: TDapplications@co.okaloosa.fl.us

OFFICE USE ONLY

Application Received Date: _____ Application Complete? Yes ___ No ___

New Applicant _____ Re-Determination Application _____

Eligible? Yes _____ *(If eligible, complete Approval Status/Review Date section below)*

Eligibility Pending? Yes _____ REASON PENDING? _____

_____ DATE NOTIFIED ____ / _____ / _____

Denied? Yes _____ REASON DENIED: _____

_____ DATE DENIED: ____ / _____ / _____

APPROVAL STATUS AND REVIEW DATE :

Temporary Disability? ____ (6 months approval) Review Date _____ / _____ / _____
Permanent Disability? ____ (3 year approval) Review Date _____/ _____/ _____
Low Income? _____ (6 months from approval date: Review Date _____ / _____ / _____
Age: Under 17? _____ (4 months from 18th birthday) Review Date _____ / _____ / _____
Age: Over 60? _____ (3 year approval) Review Date _____ / _____/_____
AT-RISK or HIGH RISK? _____ Review Date TBD Review Date _____ / _____ / _____

REVIEWED BY: _____