



DEPARTMENT OF TRANSPORTATION AND PUBLIC WORKS (DTPW)

**Para información en Español llame al (786) 469-5000
Pou enfòmasyon an Creole rele (786) 469-5000**

Dear Applicant:

This package was prepared and sent to you in response to your request to apply for the Miami-Dade Department of Transportation and Public Works (DTPW), Paratransit Administration Division, Special Transportation Service (STS). A copy of the application form is enclosed for your convenience. **Please read the enclosed material carefully before attempting to complete the application.** Information about your disability provided in this application will be kept strictly confidential.

Copies of this form are available in accessible formats upon request. If you have questions or need assistance completing this form, please contact our Paratransit Customer Service Office at: (786) 469-5000 or e-mail us at: paratransit@miamidade.gov

*****Florida Relay Service (TTY) - 1(800) 955-8771 or 711*****

Pursuant to the Americans with Disabilities Act (ADA) of 1990, Paratransit Service Provisions, STS provides shared-ride transportation service for people with disabilities who are unable to use Metrobus, Metrorail, or Metromover independently. This might include not being able to get to or from bus stops, not being able to board or disembark the bus, or not being able to understand (due to a cognitive or development disability) how to ride and use fixed route services.

To evaluate your eligibility for this service, please complete the application form and be as thorough as possible. It is important that all sections of the application are completed. If any sections are left blank, the form will not be accepted.

The DTPW goal is to continue to provide reliable and accessible transportation. All Miami-Dade County buses have lifts, ramps and the ability to lower their front end, easing access to the inside of the bus. Bus operators announce transfer points, designated points of interest, and route numbers. Priority seating for people with disabilities and the elderly is provided at the front of every bus. All Metrorail and Metromover stations are equipped with escalators and elevators, both of these services also provide priority seating. DTPW provides additional free and reduced fare services to the public including reduced fare permits, monthly and discount passes, golden and patriot passports.

**PLEASE DO NOT MAIL YOUR
COMPLETED APPLICATION
CALL 786-469-5000
TO SCHEDULE AN APPOINTMENT**

INSTRUCTIONS:

The applicant or an assistant must complete Parts I and II of the application. A Florida licensed-physician must complete and sign the MEDICAL VERIFICATION - PART III. Once you have this form completed and signed by your medical representative, **you must call Paratransit Customer Service Office at 786-469-5000 between 8:00 AM and 5:00 PM (Monday through Friday) to schedule an appointment for an in-person interview. Bring the original completed and signed application with you the day of your appointment.**

If you do not have any means of transportation, STS will be provided for you to attend the in-person interview. (Applicant rides fare free/companions pay \$3.50 STS fare each way).

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 application, we may request further documentation from your medical representative before a determination is made.

The STS Certification Unit will provide a determination within 21 days after an in-person interview has been conducted. You will receive a notification of the determination by mail. If you have not heard from us within 21 days, please call our Customer Service Office at 786-469-5000 and we will provide you with STS until your eligibility determination is processed. Please note that in some instances, we may not be able to determine your eligibility without additional medical information. In such case, we may request further documentation from your medical representative. You will receive notification of the final determination by mail.

All questions must be answered. Incomplete and/or unsigned application will not be accepted and may cause a delay in your eligibility determination. Application must have original signatures.

MEDICAL VERIFICATION: *(to be completed by a Florida licensed-physician)*

The 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 independently. The DTPW provides complementary Paratransit shared-ride service to individuals certified as per ADA Paratransit eligible. The applicant who has asked you to review and sign this form is applying to the DTPW to be considered eligible for Paratransit service. This application form will assist the DTPW to evaluate when and under what circumstances the applicant can use Metrobus, Metrorail, or Metromover service independently and when the applicant requires Paratransit service. STS shared-ride is intended only for those trips that the person cannot make on the Metrobus/Metrorail/Metromover system.

ADA GUIDELINES:

Applicants shall be individually evaluated, and eligibility shall be based on a functional ability to use conventional public transportation: Metrobus, Metrorail, and Metromover. Functional inability to use public transportation includes the ADA guidelines described below:

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.
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.

MEDICAL REPRESENTATIVE:

In order to process this applicant's request to become a qualified STS rider, we require that the medical verification section of this form be completed and signed to expedite applicant STS determination. Please attach objective medical findings, which substantiate the disability(ies). Examples include:

**Electroencephalogram (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**



ID#: _____

SPECIAL TRANSPORTATION SERVICE (STS) APPLICATION FORM

I. APPLICANT SECTION:

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

Receiving Medicaid: () Yes () No As of date: _____ Medicaid. #: ____ - ____ - ____

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

Street Address: _____ Apt. #: ____ City: ____ State: ____ Zip Code: _____

Home Phone: () _____ Email address: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____ Phone: () _____

If someone assisted the client to complete this form:

Name: _____ Relationship: _____ Phone: () _____

ETHNICITY: (for statistics only, optional)

[] White Non-Hispanic [] Black Non-Hispanic [] Hispanic [] other (specify): _____

If you need to have information given to you in an accessible format, please specify: _____

II. APPLICANT'S RELEASE OF INFORMATION:

The following information is requested to evaluate when and under what circumstances the applicant can use the County Metrobus, Metrorail, or Metromover service and when STS, shared-ride, is required. 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 extent allowed by the laws of the State of Florida. I hereby authorize my medical representative to release any and all information required by the DTPW Paratransit Certification Enrollment Office regarding my medical condition for the purpose of determining my eligibility to use 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)*
***** Please attach pertinent medical documentation of disability(ies)*****

A. Please describe the type and nature of the applicant's disability(ies) or impairment-related condition(s) (Please be as specific as possible). _____

B. Is this disability or impairment-related condition moderate to severe? Yes No

C. Is this disability: Permanent Temporary
If temporary, please provide dates: From: _____ To: _____

D. Is this applicant receiving: Radiation/Chemo Dialysis
Treatment schedule or duration: _____ From: _____ To: _____

E. Is this disability(ies) controlled by medication? Yes No

Explain: _____

F. According to your diagnosis and medical opinion can the applicant do any of the following?

Use the Bus system independently	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Walk to the bus stop	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Wait for the bus	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Board the bus with assistance of a ramp or kneeling bus	<input type="checkbox"/> Yes	<input type="checkbox"/> No
See bus signs, stops and traffic signs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Understand how to use bus (fare, orientation in the system)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Transferring from one bus route to another or to Metrorail/Metromover	<input type="checkbox"/> Yes	<input type="checkbox"/> No

What other limitation can you identify that would prevent the applicant from using public transportation? _____

G. Mobility Aid: Wheelchair Walker Crutches Braces
 Service Animal Cane None
 Other: _____
If Wheelchair user type: Manual Motorized Scooter (Three wheeled)

H. Indicate the type of transportation recommended by the applicant, based on his/her functional ability: Ambulatory (sedan/van with steps) Wheelchair (van with a lift)

I. Based on the applicant's disability, do you recommend him/her to bring a Personal Care Attendance (PCA) on each trip? Yes No

It is The DTPW policy to ensure compliance with the Health Insurance Portability and Accountability Act - 45CFR Parts 160 and 164 (HIPAA) Privacy Rule by obtaining authorization, as appropriate, from clients whose Protected Health Information (PHI) is used or disclosed for any purpose not otherwise permitted by Federal Medicaid Rules or/and the Privacy Rule.

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 independently.

NOTE: Failure to attach documentation will delay the eligibility determination process and will require DTPW to 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 statement. I understand that providing false or misleading information could result 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.

Name / Signature of Physician Date State of Florida License #

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