BOARD OF COUNTY COMMISSIONERS
BROWARD COUNTY, FLORIDA

Americans with Disabilities Act (ADA)
TOPS! Paratransit Application

Instructions for completing the Eligibility Application process

Please complete the entire application, sign all the pages requiring your signature and return it to us by mail, fax, email at **Paratransit@broward.org** or in person.

The application process requires an in-person functional assessment at our contracted facility. Upon receipt of your completed application, you will receive an orange postcard in the mail with instructions on how to schedule your appointment. If you need transportation to and from the facility, please advise them when scheduling your appointment.

We will review your file to determine your eligibility within 21 days of receipt of the completed application. You will receive your eligibility determination by mail. If a decision is not made within 21 days of receiving the completed application, you shall be treated as eligible and shall have access to paratransit transportation unless the application is denied.

If you need additional information, please contact customer service: 954.357.8400, 711 (TTY), or visit us on the web at: broward.org/BCT.

When complete, return the entire application to:

Broward County Transit - Paratransit Services
1 North University Drive, Suite 2400B
Plantation, FL 33324

Email: Paratransit@broward.org

Facsimile: 954.357.8345

ADA TOPS! Paratransit Transportation Application

PLEASE PRINT LEGIBLY

New Application? Yes ☐ No ☐ If no enter **Client ID** #: _____

Part 1 - General Information

Last Name:_____First Name:_____MI: _____

Street Address:_____Apt:____Bldg.: _____

Bldg./Subdivision Name:_____E-mail:_____

City:_____State:_____ Zip Code: _____

Cellular Phone:_____ Other Phone: _____

Date of Birth: _____

If someone assisted you to complete this form, please identify below:

Name:_____Phone: _____

Check the box to have information & material sent in another format.

☐Large Print ☐Other: _____

In case of emergency, whom do we contact? (Required)

Name:_____Phone:_____

Relationship:_____

Other Phone or E-mail: _____

Additional Contact: _____

Due to Florida privacy laws please state whom you want Broward County Transit staff to speak to on your behalf.

Name:_____Phone:_____

Address: _____

Relationship: _____ Email: _____

What is your preferred method of contact? Please check the box below.

USPS Mail ☐ Email☐ Text☐

Veterans VA trip discount:

Are you a United States veteran? ☐ YES ☐ NO
To receive the reduced discounted fare for trips to the Veteran Affairs (VA) clinics, please attach proof of your Honorable Discharge status. (DD214)

Part 2 – Questions About Using BCT Fixed-Route Buses

1. All BCT fixed route buses are low floor and fully accessible. Please describe why you are unable to ride the bus.

   _____

   _____

2. How far can you travel on your own or using your mobility aid?

   ☐ I cannot get outside my residence
   ☐ I can get to the curb in front of my residence
   ☐ I cannot see well at night

3. What might help you ride BCT fixed route buses?

   _____

   _____

4. If approved, would you travel with a Personal Care Assistant? Yes ☐ No ☐

5. If you travel with a service animal, what task does it perform for you?

   _____

   _____

6. Are you able to make your way independently to the drop off? Yes ☐ No ☐

Please Sign and Date Part 3 and Part 4
Part 3 - Applicant Certification

By signing below, you agree the information you provided is correct to the best of your knowledge*. (If you are unable to sign, your legal guardian/power of attorney may sign for you; **attach copy of the signed document**).*

I understand the purpose of this application is to determine if there are times when I cannot use the BCT fixed route service and must use ADA Paratransit services. I certify, to the best of my knowledge, that the information in this application is true and correct. I understand providing false or misleading information or making false statements on my behalf or others constitutes fraud, is considered a felony under the laws of the State of Florida and may result in a reevaluation or revocation of my eligibility.

_____ _____
Applicant's Signature Date

Part 4 - Applicant Medical Information Release

By signing below, I give permission for BCT to contact my Health Care Provider(s) to release information for the purpose of facilitating my eligibility determination or providing me with transportation. (*If you are unable to sign, your power of attorney may sign for you; **attach a copy of the signed document**).*

_____ _____
Applicant's Signature Date

ATTACH A COPY OF YOUR CURRENT GOVERNMENT ISSUED PHOTO ID WITH THIS APPLICATION.