



“Para información en español, por favor, llame al (786) 786-469-5000.”
“Pou enfòmasyon an Creole, silvouplè, rele (786) 469-5000.”

Dear Applicant:

This package was prepared and sent to you in response to your request for an application for the Miami-Dade Transit (MDT) Special Transportation Services (STS) which is our Americans with Disabilities Act (ADA) paratransit service. A copy of our “ADA Paratransit Application Form” is attached for your convenience. Please read this letter and the enclosed material carefully before attempting to complete this application. Information about your disability which you provide in the 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, call MDT at:

(786) 469-5000 (305) 263-5459 TTY/TDD or email paratransit@miamidade.gov

“ADA Paratransit” service is a van/sedan shared-ride service, comparable to standard fixed route transportation (Metrobus/Metrorail/Metromover) services. This service is provided to individuals who, because of a functional disability, are prevented from using the fixed route transportation service. This might include not being able to get to or from bus stops, not being able to get on or off buses, or not being able to understand (due to a cognitive or development disability) how to ride and use the fixed route service.

MDT will provide van/sedan shared-ride to persons that are “ADA Paratransit Eligible” for those trips that cannot be made using the county fixed route transportation service. You may, for example, be able to use county bus service for some trips there are no barriers which prevent you from getting to and from the bus stop. At other times, you might not be able to use the bus because it is not lift-equipped or there is a barrier which prevents access to the bus stop. ADA Paratransit van/sedan service is meant to assist you at these times.

There are two types of ADA Paratransit eligibility:

- Unconditional – this eligibility is granted if your disability prevents you from using county fixed route transportation service for any trip that you might need to make.
- Conditional – this eligibility is granted if you can use the county fixed route transportation service under certain circumstances, but need paratransit service for other trips.

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

Mail the completed application to MDT- Paratransit Operations, 701 NW 1st Court, Suite 131, Miami, Florida 33136.

Within 21 days of receipt of your application you will be notified by mail to schedule your certification interview.

Miami-Dade Transit's goal is to continue to provide reliable and accessible transportation. Significant changes have been made to the county fixed-route transportation system to make it more accessible to persons with disabilities. All Miami-Dade Transit buses are now wheelchair-accessible. All Metrorail and Metromover stations have ramps and elevators and other accessibility features. Miami-Dade Transit provides additional free and reduced fare services to the public including reduced fare permits, Monthly and Discount Passes, Golden and the Patriot Passport.

INSTRUCTIONS: (To be completed by the Applicant)

The applicant (or an assistant) must complete Parts I and II. A licensed physician must complete and sign the MEDICAL VERIFICATION PART III. Once you have this form completed and signed by your medical representative, please MAIL THIS APPLICATION to MDT – Paratransit Operations, 701 NW 1st Court, Suite 131, Miami, Florida 33136.

Miami-Dade Transit will process your application. As part of your processing, you may be required to attend an in-person interview. If you have no other means of transportation, STS transportation will be provided to you to attend the in-person assessment. (Applicant rides fare free)

Please note that in some instances, we may not be able to evaluate your eligibility without further information. 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 or if necessary, we may request further documentation from your medical representative before a determination is made. You will receive notification by mail of our final determination.

ALL QUESTIONS MUST BE ANSWERED. INCOMPLETE AND/OR UNSIGNED FORMS WILL NOT BE ACCEPTED AND MAY CAUSE A DELAY IN YOUR ELIGIBILITY DETERMINATION.



ID# _____
STS Application

SPECIAL TRANSPORTATION SERVICES (STS) APPLICATION FORM

I. APPLICATION 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: _____

Is this a [] House [] Apartment [] Nursing Home [] ACLF [] Boarding Home

Applicant's weight: _____ lbs. Wheelchair (if applicable) weight _____ lbs. length _____, width _____

EMERGENCY CONTACT: Name and telephone number of someone we can call in an emergency.

Name: _____ Relationship: _____ Phone: () _____

ETHNICITY: (for statistics only, optional)

[] White Non-Hispanic [] Black Non-Hispanic [] Hispanic [] Other (specify) _____

A. If you use a wheelchair, can you transfer with minimal assistance into a sedan? Y ___ N ___

Type of wheelchair: [] Manual [] Motorized [] Scooter (Three wheeled)

B. If someone assisted the client to complete this form, please specify:

Name: _____ Relationship: _____ Phone: () _____

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

II. APPLICANT'S RELEASE:

The following information is requested to evaluate when and under what circumstances the applicant can use the County bus, rail, or mover service and when Special Transportation Service (STS), van/sedan shared-ride paratransit service, 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 MDT Paratransit Certification Enrollment Office regarding my medical condition for the purpose of determining my eligibility to use Special Transportation Service (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)*

The Americans with Disabilities Act of 1990 (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. Miami-Dade Transit (MDT), Special Transportation Service (STS) provides complementary paratransit shared ride (i.e. van/sedan) service to individuals certified as ADA paratransit eligible. The applicant who has asked you to review and sign this form is applying to MDT to be considered eligible for this service. This application form will assist MDT to evaluate when and under what circumstances the applicant can use Metrobus, Metrorail, or Metromover service and when they require paratransit service. ADA/STS van/sedan shared-ride service is intended only for those trips that the person cannot make on the bus/rail/mover system.

STS ELIGIBILITY CRITERIA:

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 Americans with Disabilities Act (ADA) Categories 1, 2 and 3 as described in this application.

A. AMERICANS WITH DISABILITIES ACT (ADA) CATEGORIES:

Check the categories of eligibility that you recommend should apply.

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. (*The individual would be eligible if an accessible vehicle is not available.*)
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.
4. [] Check here, if none of these categories apply.

MEDICAL REPRESENTATIVE'S LETTERHEAD OR PRESCRIPTION FORM REQUIREMENT:

In order to process this applicant's request to become a qualified STS rider, we require that the medical certification section of this form be completed, and a letterhead or prescription form with the name and address of both the medical representative and the applicant be attached to this application. To expedite applicant processing, please attach objective medical findings which substantiate the disability. Examples include:

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

III. MEDICAL VERIFICATION (to be completed by a Florida licensed physician)

B. INDICATE THE TYPE AND NATURE OF THE INDIVIDUAL'S DISABILITIES).

CHECK AS MANY ITEMS AS MAY BE APPLICABLE. (SEE STS ELIGIBILITY CRITERIA)

1. MOBILITY IMPAIRMENT:

- a. Non-ambulatory disability (required wheelchair to travel). Please specify the condition which requires full time use of a wheelchair _____
 - b. 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).
 - I. Amputation (detail extremity): _____
 - II. Stroke without Hemiplegia III. Stroke with Hemiplegia
 - IV. Brain Spinal Nerve Trauma
 - V. Other: _____
- Date disability started: _____ (Attach EEG or neuropsychological evaluation report)

2. NEUROLOGICAL DISABILITY (motor dysfunction):

(Please attach EEG or neuropsychological evaluation report)

- a. Multiple Sclerosis b. Epilepsy c. Muscular Dystrophy d. Cerebral Palsy
- e. Parkinson's f. Alzheimer's g. Other _____

3. VISUAL DISABILITY:

- a. Totally blind
- b. Legally blind - If this person is legally blind complete the following:
 - Corrected visual acuity: Right Eye _____ Left Eye _____ (Attach Snellen reports of both eyes)
 - Corrected field of vision: Right Eye _____ Left Eye _____ (Attach Perimeter chart reports both eyes)

4. COGNITIVE DISABILITY:

a. Type of mental impairment:

- Emotional Autism Adult retardation Dementia
- OBS Alzheimer's Development Disability Other

(Attach EEG or neuropsychological evaluation showing full scale intelligent quotient "FSIQ" or mental age, as applicable.)

- b. Level of mental impairment: Mild Moderate Severe Profound, I.Q.: _____
(Must Specify)

5. UNCONTROLLED FATIGUE:

- a. Radiation/Chemo b. Dialysis If either a. or b. is marked please provide the following:

Treatment Schedule (or duration): _____ Treatment Start and expected End date: _____ thru _____

Treatment Center: _____ Address: _____

- c. HIV (Attach Elisa, Western Blot result reading CD4 + counts.) d. Other _____

6. IMPAIRMENT RELATED CONDITION:

- a. Arthritis (Please attach MRI/CA T/X - ray findings or operative reports of area affected)
{Functional Classification _____ Anatomical Stage _____} b. _____ Other
- b. Cardiac (Please attached EKG or operative findings)
{Functional Classification _____ Therapeutic Classification _____}
- c. Respiratory (Must Specify) {FVC _____ FEV1 _____} (Attach oxymetric capability report)

C. DESCRIBE IN DETAIL THE APPLICANT'S PRIMARY DISABILITY: (BE SPECIFIC)

- D. IS THIS DISABILITY: Permanent Temporary (If temporary, date of disability _____ & length of recovery _____)

- E. IS THIS DISABILITY CONTROLLED BY MEDICATION? Yes No

Explain: _____

