



Date _____

Passenger Information

Name: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ Social Security #: _____ - _____ - _____

Date of Birth: ____/____/____ Phone #: _____ Home Cell

Emergency Contact: _____ Relationship: _____

Emergency Contact: _____
Address City State Phone#

Email Address: _____

Eligibility

Transportation Eligibility is limited to individuals who have little or no access to transportation due to income (150% of the Federal Poverty Level); are over the age of 60; or have a disability that prevents the individual from driving. You must include a copy of the selected documentation to be approved for service. Completing this application does not automatically certify you for service. Applicants may be required to undergo a functional assessment to assist FCPT in determining your level of eligibility.

Please include a copy of ALL supporting documentation for each selected section to confirm eligibility:

I am unable to transport myself or purchase transportation because I am:

Low Income – Combined Annual Household Income: \$ _____

- DCF Benefit SSI Statement or Proof of Income Medicaid Card Housing Benefit
- Unemployment Compensation Other: _____

Over the age of 60 – Date of Birth: _____ Verified By: _____

- State Issued ID card and/or DL Copy of Birth Certificate Other: _____

Disabled – Unable to operate a vehicle Verified By: _____

- Disabled Veteran Letter Doctor's Note Other: _____

Do you own a vehicle? YES NO Does anyone in your household own a vehicle? YES NO

How are you transported to appointments currently? _____

Do you have relatives/friends that can transport you? YES NO If no, why? _____

Do you live in a facility that provides transportation? YES NO Can the facility transport you? YES NO

If no, please explain why: _____

Please provide the name of the facility you reside, if applicable: _____

Do you have weekly scheduled appointments? YES NO Which days? M T W T F S Time: _____

Mobility Aids

Please select any and all special needs or mobility aids you may require:

- Manual Wheelchair Powered Wheelchair Powered Scooter Walker Cane Personal Care Attendant (PCA) Respirator Service Animal Child Car Seat White Cane

Do you have any other needs/conditions that we need to be aware of in order to transport you safely?

- YES NO

If YES, please explain: _____

Certification & Acknowledgement

I understand and affirm that the information provided in this application is true and correct to the best of my knowledge. I understand that providing false or misleading statements constitute a felony under the laws of the State of Florida. I have read and understand all of the rules and policies that I am responsible for in the *FCPT Rider's Guide* I was provided with this application.

Flagler County Public Transportation collects your social security number for verification purposes only. Social Security numbers are a unique identifier and may be used for search purposes. Social Security numbers will never be shared.

Signature: _____ Date: ____/____/____

Return Completed Form To:
Flagler County Public Transportation
1769 East Moody Boulevard,
Building 5
Bunnell, Florida 32110
EMAIL TO FCPT@flaglercounty.gov

DO NOT WRITE IN THE SPACE	RED INK ONLY	OFFICE USE ONLY
Applicant's Client ID#: _____	<input type="checkbox"/> TD Funding Source	<input type="checkbox"/> FDOT Funding Source <input type="checkbox"/> ADA
<input type="checkbox"/> New Eligibility <input type="checkbox"/> Redetermination	Received Date: ____/____/____	
Reviewed By: _____	Date: ____/____/____	
<input type="checkbox"/> Approved Criteria: <input type="checkbox"/> Age 60+ <input type="checkbox"/> Below 150% Poverty <input type="checkbox"/> Disabled <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Denied – Reason: _____		
<input type="checkbox"/> Pending – Reason: _____		
Applicant Notified Date: ____/____/____	Method: <input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email	