

Applicant Name \_\_\_\_\_

**LAKE COUNTY CONNECTION**  
**Application for Transportation Disadvantaged Services**

**Instructions to Applicant or Proxy:**

1. Please be sure to print and complete all information requested and sign where indicated.
2. All provided information may be verified and confirmed. You may attach supporting documentation.
3. Completing this application does not automatically certify you for paratransit services. Applicants may be required to go through a functional assessment to assist us in determining your level of eligibility. All applicants will be notified of the outcome of their application.

If you would like to be notified by e-mail, please check this box.

**WHEN COMPLETED, PLEASE RETURN THIS FORM TO:**

Lake County Connection  
P.O. Box 491597  
Leesburg, FL 34749

Telephone: (352) 326-2278  
Fax No. (352) 365-2982  
E-mail: [lc-cert@ride-right.net](mailto:lc-cert@ride-right.net)

**OFFICE USE ONLY**

Date Received: \_\_\_\_\_ New Application:  Approved  Date: \_\_\_\_\_  
Recertification:  Denied  Date: \_\_\_\_\_

Reason for Denial: \_\_\_\_\_  
\_\_\_\_\_

Reviewed By: \_\_\_\_\_ Funding Source: FDOT  Medicaid   
TD

Applicant Notified By: \_\_\_\_\_ Date: \_\_\_\_\_

Method Used to Notify Applicant: Telephone  Mail   
E-mail  Other  \_\_\_\_\_

Last Name	First Name	Middle Initial	M/F
____/____/____	_____ - _____ - _____	_____	_____
Date of Birth	Social Security Number (Medicaid recipients only.)	Medicaid Number	

Home Address	Apt./Lot No.
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City	County	State	Zip Code
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Complex/Subdivision/Facility Name	Nearest Intersecting Street	Nearest Bus Route
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If this is a gated community, please provide gate code. \_\_\_\_\_

Home Phone	Work Phone	Cell Phone	E-mail Address
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Mailing Address	Apt./Lot No.	City	County	State	Zip Code
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**In case of emergency, please contact:**

Name	Relationship to You	Home Phone	Cell Phone	Work Phone
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If we are unable to reach the Primary Emergency Contact listed above, please provide a secondary emergency contact.

Name	Relationship to You	Home Phone	Cell Phone	Work Phone
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**Please check all that apply to you.**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Portable Oxygen  | <input type="checkbox"/> Assisted Walking | <input type="checkbox"/> Needs Escort   | <input type="checkbox"/> Wheelchair       |
| <input type="checkbox"/> Sight Impairment | <input type="checkbox"/> Cane             | <input type="checkbox"/> Crutches   | <input type="checkbox"/> Walker           |
| <input type="checkbox"/> Service Animal   | <input type="checkbox"/> Stretcher        | <input type="checkbox"/> Mental Impairment (i.e. Dementia, Alzheimer's, etc.) | <input type="checkbox"/> Hearing Impaired |

Do you have weekly scheduled medical appointments? Yes \_\_\_ No \_\_\_

How many medical appointments do you have in a month? \_\_\_

How do you currently travel to your destination?

\_\_\_ Bus \_\_\_ Taxi \_\_\_ Drive Yourself \_\_\_ Other (Please explain) \_\_\_\_\_

What prevents you from driving your car? \_\_\_\_\_

Do you have relatives or friends who can transport you? Yes  No

What are the names and ages, including yourself, of the people living in your household?  
\_\_\_\_\_

Does anyone living in your household own a car? Yes  No

What is the **combined** monthly household income of everyone living in the home? \_\_\_\_\_

Are you currently receiving public assistance such as food stamps? Yes  No

**Monthly Income:** In order to process your application, proof of income must be submitted with your application.

Salary \$ \_\_\_\_\_ SSI \$ \_\_\_\_\_ Social Security \$ \_\_\_\_\_ Retirement \$ \_\_\_\_\_ Other \$ \_\_\_\_\_

**Monthly Expenses:** If you are a roomer or boarder you must provide a notarized statement from your landlord listing the amount you pay for board, utilities and meals.

Housing \$ \_\_\_\_\_ Utilities \$ \_\_\_\_\_ Vehicle \$ \_\_\_\_\_ Food \$ \_\_\_\_\_ Cable \$ \_\_\_\_\_

Phone \$ \_\_\_\_\_ Cell Phone \$ \_\_\_\_\_ Medical \$ \_\_\_\_\_ Pharmacy \$ \_\_\_\_\_ Fuel \$ \_\_\_\_\_

Home Insurance \$ \_\_\_\_\_ Car Insurance \$ \_\_\_\_\_ Other \$ \_\_\_\_\_

**Total Monthly Household Expenses** \$ \_\_\_\_\_

Would you ride LakeXpress if you were provided with a free bus pass? Yes  No

**Functional Ability**

Without the assistance of someone else, can you:

Board a bus?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Read/understand directions?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Handle coins and bus transfers?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Travel on a sidewalk?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Travel to the nearest bus stop?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stand at a bus stop?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Identify the correct bus?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Walk ¾ mile?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Climb a 12 inch step?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cross a street?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Balance yourself while seated?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Grip handles and railings?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Give your address and phone number?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Recognize landmarks?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Wait outside for more than 15 minutes?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Travel through crowds?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Please check the condition(s) which prevents you from accessing a regular LakeXpress fixed route bus.

\_\_\_\_\_ None

\_\_\_\_\_ The bus stop is too far or the bus does not run where I need to go.

\_\_\_\_\_ My disability prevents me from using the regular fixed route bus system.

\_\_\_\_\_ I need transportation to and from medical appointments outside of Lake County.

**Certification and Acknowledgement**

I understand and affirm that the information provided in this application for Non-Emergency Transportation Disadvantaged services 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 for transportation to and from eligible services as well as appointments.

I understand that providing false or misleading information or making fraudulent claims or making false statements on behalf of others could constitute a felony under the laws of the State of Florida and could result in my eligibility status being revoked. I agree to notify Lake County Connection if there is any change in circumstances or I no longer need to use Paratransit services. I understand if I am approved for the Transportation Disadvantaged Program I must be recertified one year from the date of approval for services.

Lake County Board of County Commissioners and our Operator, Ride Right, LLC collects your social security number, if applicable, for the following purposes:

- Identification and verification
- Billing and payments
- Benefit processing

Social security numbers may be used as a unique numeric identifier and may be used for search purposes.

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Applicant's Signature

Date

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Signing for Applicant

Relationship

Date