ACCESS LYNX
TRANSPORTATION
DISADVANTAGED (TD) PROGRAM

Thank you for your interest in the Transportation Disadvantaged (TD) program which is a shared-ride door to door service provided to eligible residents of Orange, Osceola, and Seminole counties.

Eligibility:

To be eligible for the TD program, the applicant must meet **two of the three** following criteria:

1. Have no access to a fixed route.
2. Have a disability.
3. Have an income level at or below 185% of Federal Poverty level.

Note: The Federal Poverty Guidelines are published annually and applied to this program for income level qualification based solely on individual applicant income – not the applicant's household income. For reference, the Guidelines can be viewed at: www.aspe.hhs.gov.

If the disability criteria is applicable, the Medical section of this application (Section 4) must be completed and signed by a Licensed Medical Professional. You may attach supporting documentation to this application.

You are required to provide identi ication and applicable inancial supporting documents upon submission. Self-declaration of income is not accepted. Processing may take up to 21 days from receipt of completed application.

We will make every effort to verify your individual income and any medical information provided. If necessary, further information may be requested to determine eligibility.

Completed TD applications must contain all requested information. Please be sure to sign this application where appropriate, and attach a copy of your Florida ID or Driver's license along with all other required supporting documentation.

Mail Completed Application to:
ACCESS LYNX (Eligibility)
455 N Garland Ave.
Orlando, FL 32801
Fax Application to: (407) 849-6759
Information: (407) 423-8747 (select Option 6)

FOR OFFICE USE ONLY:
Client ID: _____

DATE RECEIVED _____
NEW _____RECERT _____

For Life Sustaining Trips Only – Check Here: ☐ Dialysis Only ☐ Cancer Treatment Only

APPLICATION: General Information (SECTION 1)

_____ Date of Birth

_____ Last 4 of Social Security Number

_____ Last Name

_____ First Name

_____ Middle Initial

_____ Home Address

_____ Apartment Number

_____ City

_____ County

_____ State

_____ Zip Code

_____ Complex/Subdivision/ Facility Name

_____ Gate Code

_____ Home Phone

_____ Work Phone

_____ Cell Phone

_____ Email address

_____ Mailing Address

_____ Apt Number

_____ City

_____ County

_____ State

_____ Zip Code

Emergency Contact:

_____ Name

_____ Relationship

_____ Phone number

_____ Address / Apt Number

_____ City

_____ County

_____ State

_____ Zip Code

Please check all that apply to you:

- ☐ Service Animal
- ☐ Cane
- ☐ Sight Impairment
- ☐ Assist Walking
- ☐ Crutches
- ☐ Walker
- ☐ Hearing Loss
- ☐ Deaf
- ☐ Need Attendant
- ☐ Power Scooter
- ☐ Portable Oxygen
- ☐ Mental Impairment
- ☐ Manual Wheelchair
- ☐ Power Wheelchair
- ☐ Blind/Legally Blind
- ☐ Wide Wheelchair
- ☐ Mental Impairment (Do not Leave Unattended)

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?

☐ LYNX (City bus) ☐ Taxi ☐ TNC ☐ Drive yourself ☐ Other ☐ ACCESS LYNX

Please check the condition which prevents you from accessing a regular LYNX fixed route bus:
☐ The bus stop is too far (more than ¾ mile).

☐ The bus does not run where I need to go/when I need to go for employment.

☐ I have a disability that prevents me from using the LYNX fixed route bus.

Explain:_____

_____

Verification of Income (SECTION 2)

Total Individual Monthly Income $_____

Please attach proof of your total income **before** tax, including wages, tips, any Social Security income, pension, and other income. Acceptable forms of income verification include the following:

1. Minimum of two (2) most recent pay stubs $_____
2. DCF Cash Benefits/ Child support letter $_____
3. Unemployment Compensation income verification $_____
4. Social Security Proof of Income Letter (SSA/SSI/SSDI) $_____
5. Retirement / Pension statement (Include VA) $_____
6. First page of your most recent tax return $_____
7. Other (specify) $_____

*A Self-Declaration will not be accepted as proof of lack of income.

If you have $0.00 income, and you live in a house or apartment, please indicate how your rent/utilities are paid (this includes balance remaining after rent subsidy).

Additional documentation may be required to support individual income.

Applicant's Verification of Completion and Release: (SECTION 3)

Application Checklist:

Did you attach a copy of your Florida ID or Driver's license?	☐ YES	☐ NO
Did you attach all required documents?	☐ YES	☐ NO
Is the Medical Form completed by a Licensed Medical Professional?	☐ YES	☐ NO

Acknowledgments, Authorization, and Release by Applicant

I understand that the purpose of this application including the request for supporting documentation is to determine my eligibility for "Transportation Disadvantaged" Service. I understand that the information about my disability (if any) contained in Section 4 of this application and in any supporting documents will be kept confidential and shared only with LYNX employees and professionals involved in evaluating my eligibility.

I hereby authorize my medical representative to release any and all information regarding my medical condition to LYNX as it applies to this evaluation including without limitation the information requested in Section 4 of this application.

I affirm that the information in this application package is true and correct to the best of my knowledge. I understand that providing false or misleading information could result in my eligibility status being revoked. I agree to notify ACCESS LYNX within 10 days if there is any change in circumstances or I no longer need to use the transportation services.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Preparer (if other than applicant) Date

_____ _____

Print Name (Preparer) Relationship

Medical Form (SECTION 4)

Instructions for Licensed Medical Professional: Please complete the section below. The information that you provide must be based solely upon the applicant having an actual physical or mental impairment that substantially limits one or more major life activities.

Applicant Name: _____ Date of Birth:_____

What is the applicant's disability or condition? _____

☐ Cognitive Impairment ☐ Functional ☐ Hearing ☐ Visual
☐ Uncontrolled Fatigue ☐ Emotional ☐ Neurological

Is the applicant's disability or condition: ☐ Permanent? ☐ Temporary?
If Temporary, what is the expected duration? _____

Are any of the following affected by the individual's disability? (Check all that apply)

☐ Orientation ☐ Monitoring time ☐ Gait or balance
☐ Problem Solving ☐ Judgment ☐ Inconsistent performance
☐ Short-term Memory ☐ Communication ☐ Long-term memory
☐ Inappropriate social behavior ☐ Do Not Leave Unattended
☐ Other (please explain) _____

If applicant is currently taking prescribed medication(s), do any of the medications enhance or diminish the individual's functional ability to travel independently? ☐ Yes ☐ No
If yes, please explain. _____

_____

I, the undersigned, certify the medical information provided on the TD Application is true and correct. I understand providing false or misleading information constitutes fraud and is considered a felony under the laws of the State of Florida.

_____ _____
Licensed Medical Professional's Signature Medical License Number

_____ _____
Licensed Medical Professional Name (Print Legibly) Contact Number

_____
Contact Address