JACKSONVILLE TRANSPORTATION AUTHORITY
PARATRANSIT ELIGIBILITY APPLICATION
Transportation Disadvantage (TD) Service

All questions must be completed to process this application.

Thank you for inquiring about eligibility for the JTA Transportation Services. Attached is a copy of a Transportation Disadvantaged Application form. Please read the following information before completing the application.

The JTA Connexion is a transportation service that offers door-to-door service to eligible individuals who cannot access the mass transit system some or all of the time. This application is for certification to use the JTA Connexion service. This application consists of requirements for the applicant to complete. Please be sure to fill out the application completely. An incomplete application may delay the processing.

"When you complete the application and have gathered any supporting documentation as requested you must return all of the information to our office at the address on the application. Also, please enclose a copy of your picture ID. Once we have received your paperwork, we will process it and you will receive your notification by mail."

Accessible versions of these forms are available upon request; Braille, large print, or assistance with completing the application by one of the JTA Eligibility staff members.

GENERAL INFORMATION (PLEASE PRINT)

Last Name: ________________________________First Name: ________________________________ M. I.: ___

Residential Address: ____Apt/Lot#_________

City: _________________________________ State: ________________ Zip: _____________ County: __________

Is the provided address your mailing address? ☐Yes ☐No Email Address: ______________________________

If not, please provide mailing address: ____

Daytime Phone Number: _______________________ Alternate Phone Number: __________________________

Date of Birth: ______________________________ Gender: ☐Male ☐Female

Emergency Contact: ____________________ Relationship: ________________ Telephone#: ________________

Check the following residence type in which you live:

☐Home ☐Apartment/Townhouse ☐Retirement Facility ☐Assisted Living Facility ☐Skilled Nursing Facility

Name of Facility, if applicable:____

When you travel outside your home, please indicate which (if any) of the following mobility aids you use:

☐Power Wheelchair ☐Walker ☐White Cane ☐Service Animal
☐Wheelchair ☐Cane ☐Respirator ☐Personal Care Assistant (PCA)
☐Scooter ☐Crutches ☐Stretcher ☐Other ____________
☐No Mobility Aid

If you use a manual wheelchair, can you transfer to a passenger seat for travel? ☐Yes ☐No ☐N/A

Are you a disabled veteran? ☐Yes ☐No (If yes, please attach a copy of VA letter of disability)

Do you receive SSI or SSDI? ☐Yes ☐No (If yes, please attach copy of documentation.)

State Transportation Disadvantage (TD) Program

1. Do you have a Driver's License? ☐Yes ☐No
If yes: License Number: __________________________ State: ______ Expires: ______________________

2. Do you or any member of your household own a vehicle? ☐Yes ☐No
List make, model and year for each: ____

3. Can you or a member of your household transport you to your appointments? ☐Yes ☐No
If not, why: ____

4. Please indicate the number of people (including yourself) residing in your household:

Name	Relationship	DOB	Driver License and Expiration Date

5. Do you live in a facility that provides transportation? ☐Yes ☐No
If yes, can this facility provide you with transportation to your medical appointments? ☐Yes ☐No
If no, why not: ____

6. Are you currently receiving dialysis or oncology (cancer) treatments? ☐Yes ☐No
If yes, how many times per week? ______.
Please provide the name of the facility where you receive these treatments: ______________________

7. Are you currently eligible for Medicaid NET (non-emergency transportation)? ☐Yes ☐No

8. Do you live on a bus route or in a ReadiRide area? ☐Yes ☐No
If yes, please indicate why you are not able to use public fixed-route transportation
(JTA bus/ ReadiRide): ____

9. Please list all facilities that you visit on a regular basis:

Name and Address of facility	Type of visit	# of monthly visits	Describe how you previously got there

10. Are there any other transportation needs of which we should be aware including culture competency?
____

11. Please attach a copy of one of the following:
☐Birth Certificate ☐JTA Senior ID Card (Sunshine Pass) ☐Florida State ID Card
☐Florida Driver's License ☐Other Government photo ID with date of birth.

"REQUIRED: Total Household Monthly Income $_________. (Please be sure to include ALL sources of income for ALL members of your household) Please attach a copy of any of the following to show all sources of household income for the past three months: ● Paycheck or stub ● Social Security check or stub ● Bank Statement ● Other income statement, check or stub."

Applicant Signature

I acknowledge the purpose of this application is to determine my ability to use transit and paratransit services. I understand that the staff of the Jacksonville Transportation Authority (JTA) and JTA Connexion may need to discuss my application to obtain additional information. I have been truthful in answering all these questions and my information may be verified. I authorize the health care professional, including psychiatrists or psychologists, designated in this application to release and provide JTA and JTA Connexion, or its representatives, any additional information that may be required to complete or clarify this application. I agree that, when possible, I will travel to the nearest location that can serve my needs and understand that this will allow JTA to most efficiently serve the needs of the community.

I certify that, to the best of my knowledge, the information given is correct.

Please note that any person who knowingly makes a false or misleading statement in an application or certification under section 320.0848, Florida Statutes, commits a misdemeanor of the first degree, punishable as provided in section 775.082 or 775.083, F.S. The penalty is up to one year in jail or a fine of $1,000.

Applicant Signature:____ Date:_________________

If applicant signed their name above, but you helped this person to answer these questions, please sign and print your name below:

Signature: ____

Printed Name: ____

Relationship to Applicant: ____

Phone Number: ____

Please return completed application and applicable documentation to:
Connexion Eligibility Center
100 N Myrtle Ave Building 2
Jacksonville, FL 32204
(Phone: 904-265-6001)

“DID YOU REMEMBER TO INCLUDE YOUR TOTAL HOUSEHOLD INCOME FOR ALL WHO LIVE IN THE HOME?”

“ENSURE TO INCLUDE COPIES OF ALL THE DOCUMENTS REQUESTED.”

CONNEXION ELIGIBILITY CENTER

MEDICAL INFORMATION FORM

100 N. Myrtle Ave Building 2
Jacksonville, FL 32204

Applicant Name ____ DOB ______________________

Medical Verification – To be completed by a 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 cognitive limitation, which prevents the use of our fixed route bus service. The diagnosis of a potentially limiting illness or condition is not sufficient determination for paratransit services.

1. What is the applicant's disability?
   ____
   ____
   ____

2. How does the condition functionally prevent the applicant from using regular bus service?
   ____
   ____
   ____

3. If temporary, what is the duration?
   ____

4. Does this individual use a mobility aid? ☐Yes ☐No If yes, what type of mobility aid do they use?
   ____
   ____

5. If this individual is currently taking prescribed medication(s), does this medication enhance or diminish the individual's functional ability to travel independently? Please explain:
   ____
   ____
   ____

6. 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
   ☐Other (please explain) ____

7. Please feel free to let us know if you have any other comments: ______________________________
   ____
   ____
   ____

Signature of Medical Professional ________________________________ Date_____________

Professional License # ________________________________ State Issued ________________

Print Name____

Address____

City ___________________________________ State________________ Zip Code __________

Phone # _____________________________________ Extension ________________________

Contact person ____

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____

Applicant Signature Date

If an applicant is unable to sign this form, he/she may have someone sign on his/her behalf.

____

Signing for Applicant Relationship Date