Liberty County Transit
Transportation Disadvantaged Transportation Fund
Eligibility Policy and Procedures

POLICY:

Florida Statute 427.011(1) - "Transportation disadvantaged" means those persons who because of physical or mental disability, income status, or age are unable to transport themselves or to purchase transportation and are, therefore, dependent upon others to obtain access to healthcare, employment, education, shopping, social activities, or other life-sustaining activities, or children who are handicapped or high-risk or at-risk as defined in Florida Statute 411.202.

To be eligible for Transportation Disadvantaged Transportation Funded (TDTF) services, an applicant must complete a Non-Sponsored Eligibility Application and provide applicable verification and documentation.

Applicant must have no other means of transportation available nor any other funding source or purchasing agency that can provide transportation and meet at least one of the following criteria:

1. The applicant is age 60 or older, or 17 and under; or
2. The applicant's income does not exceed 150% of the current Federal Poverty Guidelines; or
3. The applicant has a physical or mental disability and is unable to transport themselves and is dependent upon others for their transportation needs.

APPLICATION PROCESS:

Eligibility determination will be performed by the Transportation Director, or Program Coordinator.

TDTF eligibility applications are available for pick up at our office or can be mailed to the applicant upon request.

Prior to receiving services, the signed application, along with all required supporting documentation, must be received by Liberty County Transit, determined eligible and documented on the form.

If the application is not complete in its entirety or supporting documents are missing, the Executive Director, Program Coordinator, or Dispatcher will contact the applicant by phone or mail to request the missing information. If the missing information is not received within 21 days of notice, the application processing will be discontinued, the application will be filed as incomplete, and TDTF services will not be provided for the applicant. If the applicant decides at a later date to re-apply, the application will be treated as a new application and will follow the same process as a new application.

Applicants approved to be eligible for TDTF services will be notified of the approval by phone or mail within 10 business days of receipt of the completed application and all required supporting documentation.

In the event that an applicant is determined to be ineligible for TDTF services, the applicant will be notified in writing within 10 business days of receipt of the completed application and all required supporting documentation with the reason(s) for the denial. Information will be included for the applicant to appeal the decision, if they so desire. The Executive Director or the Program Coordinator will review all appeals submitted along with any additional information to support the appeal. A determination letter will be mailed to the applicant within 5 business days of receipt of the appeal. If the applicant is still not satisfied with the outcome of the eligibility determination, then the procedures outlined in the Local Grievance Procedure/Process in the TDSP will be followed.

In certain rare cases, an applicant may be granted provisional TD eligibility for a period of 21 days while the application is being submitted and processed in order that necessary life sustaining transportation services may be provided (i.e., transportation for cancer treatments or dialysis). There must be a completed and approved eligibility application and eligibility determination form in place by the end of the 21 days or transportation services will no longer be provided.

If it is determined that an applicant is approved as temporary, the reason for the temporary status and the dates of approved service will be noted on the eligibility determination form. Typically, a medical professional will make the temporary determination. However, when an applicant is seeking temporary approval due to an unusual event such as a colonoscopy or cataract surgery, the Executive Director, or Program Coordinator can grant the temporary approval.

All applicants are to be recertified every 5 years unless stated otherwise on the applications.
All applications will be reviewed at least once per year verifying and updating information.

APPENDIX A – TRANSPORTATION DISADVANTAGED ELIGIBILITY APPLICATION

APPENDIX B – ACCEPTABLE MEANS OF VERIFICATION

APPENDIX C – HEALTH AND HUMAN SERVICES 2017 POVERTY GUIDELINES

Liberty County Transit

15629 NW County Road 12
P.O. Box 399
Bristol, FL 32321
(850) 643-2524 Fax: (850) 643-5672

Transportation Disadvantaged (Non-Sponsored Services) Eligibility Application

To be eligible for Transportation Disadvantaged Transportation Funded (TDTF) services, an applicant must complete a Non-Sponsored Eligibility Application and provide applicable verification and documentation.
Applicant must have no other means of transportation available nor any other funding source or purchasing agency that can provide transportation and meet at least one of the following criteria Check ALL that applies to the applicant for Transportation Disadvantaged Assistance.

- ☐ 17 and under or over 60 years of age **(ANSWER SECTIONS A & D); or**
- ☐ Low Income **(ANSWER SECTIONS A, B, & D); or**
- ☐ Mental or Physical Disability **(ANSWER SECTIONS A, C, & D)**

Section A
Applicant Information

Last Name: _____ **First Name:** _____ **M.I.** _____

Address: _____ **City:** _____ **ST** _____ **Zip:** _____

Home Phone: _(_____)_____ **Cell Phone:** _(_____)_____

Age: _____ **Date of Birth:** _____/_____/_____ **Sex: Male:** _____ **Female:** _____

Marital Status: _____ **Number in Family:** _____

Medicaid ID # or Card Control# _____ **(if applicable)**

Directions to your Home:

_____

_____

Emergency Contact:

Name: _____ **Relationship:** _____

Phone: _____

1. Do you own or have access to a vehicle or other means of transportation?

   YES _____ NO _____

   If you answered 'yes' to No. 1, please explain why you or other household members are unable to transport you to medical and other trips.

   _____

   _____

Section A
CONTINUED

Please list ALL Household Member Information that is applicable:

Name: _____ **Relationship to Applicant** _____ **M** ____ **F** ____

Birth Date: ____/____/_____ **Medicaid ID or Card Control #** _____

Name: _____ **Relationship to Applicant** _____ **M** ____ **F** ____

Birth Date: ____/____/_____ **Medicaid ID or Card Control #** _____

Name: _____ **Relationship to Applicant** _____ **M** ____ **F** ____

Birth Date: ____/____/_____ **Medicaid ID or Card Control #** _____

PLEASE ATTACH A COPY OF ONE OF THE FOLLOWING FORMS FOR AGE VERIFICATION

Birth Certificate
Driver license
ID card
Pass Port

Section B
INCOME VERIFICATION

1. Is the Applicant Employed? Yes _____ No _____
2. If Married, is Spouse Employed? Yes _____ No _____
3. Does the applicant receive Florida Medicaid Insurance? Yes _____ No _____
   IF YES, PLEASE SUBMIT A COPY OF A VALID CARD
4. TOTAL Gross Monthly Household Income $_____
5. TOTAL Number of Members in Household _____

PLEASE ATTACH A COPY OF ONE OF THE FOLLOWING FORMS INCOME VERIFICATION

1st page of applicant's last year's tax return
Unemployment Compensation Income Verification
Medicaid Card
DCF Benefit Statement
Social Security Income Verification or Proof of Income Letter (includes SSI and SSDI)
Minimum of two (2) pay stubs
Retirement/Pension Statement
Bank Statement showing Social Security Income and/or Retirement Income
A notarized letter from a relative or non-relative regarding support.

Section C
DISABILITY ELIGIBILITY

1. Is the applicant physically or mentally disabled? Yes _____ No _____
   If yes, does the applicant have Medicare or Florida Medicaid? Yes _____ No _____
   If yes, please submit a copy of the Medicare or Florida Medicaid Card.

2. Is this application for a handicapped child? Yes _____ No _____
   If yes, does the applicant have Medicare or Florida Medicaid? Yes _____ No _____
   If yes, please submit a copy of the Medicare or Florida Medicaid Card.

PLEASE ATTACH A COPY OF ONE OF THE FOLLOWING FOR DISABILITY VERIFICATION:

Medicare Card
Letter on a physician's/medical professional's letterhead stationary
Letter from a Federal Government agency that issues or provides disability benefits
Letter from a state Vocational Rehabilitation Agency counselor
Letter from a private Vocational Rehabilitation or other counselor that issues or provides disability benefits

Section D
Special Needs Questionnaire

TO ENSURE THE BEST SERVICE, PLEASE CHECK OR LIST ANY SPECIAL ACCOMMODATIONS YOU USE WHILE BEING TRANSPORTED:

NONE NEEDED _____ Cane _____ Walker _____ Oxygen _____
Companion Rider _____ Personal Care Assistant _____
Manual Wheelchair _____ Extra-Wide Wheelchair _____ Scooter_____
Power Wheelchair _____ Stretcher _____
Service Animal: _____ Other _____

Certification and Acknowledgment

I understand and affirm that the information contained in this application for Transportation Disadvantaged financial and transportation assistance 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 of transportation to and from eligible services and appointments. I understand that providing false, incomplete or misleading information or making fraudulent claims or making false statements on behalf of others constitutes a felony under the laws of the State of Florida.

Applicant Signature: _____ Date: _____/ _____/ _____

PLEASE RETURN COMPLETED APPLICATION ALONG WITH COPIES OF ELIGIBILITY QUALIFYING DOCUMENTS TO:

Liberty County Transit

P.O. Box 730

Bristol, FL 32321

(850) 643-2524 or Fax: (850) 643-5672

libertyt@gtcom.net

Office Use Only

Application Received Date: _____/ _____/ _____ Application Complete? Yes _____ No _____

New Applicant? Yes _____ No _____

Approval Status and Review Date

Temporary Status? _____ Reason: _____

_____ Approved Until: _____/ _____/ _____

Disability? _____ Recertification Due: _____/ _____/ _____

Low Income? _____ (evaluated every 2 years) Recertification Due: _____/ _____/ _____

17 and Under? _____ (Review on 18th birthday) Recertification Due: _____/ _____/ _____

Over 60? _____ Recertification Due: _____/ _____/ _____

Reviewed By: _____

Eligible? Yes _____ No _____

Eligibility Pending? Yes _____ Reason Pending: _____

_____ Date Notified _____/ _____/ _____

Denied? Yes _____ Reason Denied: _____

_____ Date Notified _____/ _____/ _____

Client Contacted:

Phone: _____/ _____/ _____ _____/ _____/ _____ _____/ _____/ _____

Mailed: _____/ _____/ _____ _____/ _____/ _____ _____/ _____/ _____

Notes:

_____

_____

_____

Annual Application Review:

_____/ _____/ _____ _____/ _____/ _____ _____/ _____/ _____ _____/ _____/ _____

Persons in Household 150% Poverty Level 2018	Monthly	Yearly
1	$1,517.50	$18,210
2	$2,057.50	$24,690
3	$2,597.50	$31,170
4	$3,137.50	$37,650
5	$3,677.50	$44,130
6	$4,217.50	$50,610
7	$4,757.50	$57,090
8	$5,297.50	$63,570
Each Additional	$540.00	$6,480.00

APPENDIX B

EXAMPLES OF ACCEPTABLE MEANS OF VERIFICATION:

1. No other funding sources available:
   - *Answer to question on Application*
2. No other means of transportation:
   - *Answers to questions on eligibility application*
3. Age:
   - *Birth Certificate*
   - *Driver license*
   - *ID card*
   - *Passport*
4. Income:
   - *1st page of applicant's last year's tax return*
   - *Unemployment Compensation Income Verification*
   - *Medicaid Card*
   - *DCF Benefit Statement*
   - *Social Security Income Verification or Proof of Income Letter (includes SSI and SSDI)*
   - *Minimum of two (2) pay stubs*
   - *Retirement/Pension Statement*
   - *Bank Statement showing Social Security Income and/or Retirement Income*
   - *A notarized letter from a relative or non-relative regarding support.*
5. Physical or mental disability:
   - *Medicare Card*
   - *Letter on a physician's/medical professional's letterhead stationary*
   - *Letter from a Federal Government agency that issues or provides disability benefits or copy of benefits statement*
   - *Letter from a state Vocational Rehabilitation Agency counselor*
   - *Letter from a private Vocational Rehabilitation or other counselor that issues or provides disability benefits*

FAMILY SIZE	FPL FOR 2020	FPL FOR 2021
1	$12,490.00	$12,760
2	$16,910.00	$17,240
3	$21,330.00	$21,720
4	$25,750.00	$26,200
5	$30,170.00	$31,800
6	$34,590.00	$37,400
Each Additional Person	add $4,420 each	add $5,600 each