Lee County
Southwest Florida

Board of County Commissioners

TRANSPORTATION DISADVANTAGED (TD) APPLICATION INSTRUCTIONS

- Applicant or caregiver completes the TD Program Application.
- Applicant or caregiver completes the emergency contact form.
- Applicants applying **must** provide proof of the household income.
- Applicants submits a copy of a government issued identification with date of birth.
- Applicants can fax, mail, or submit the completed form at the address below.

The eligibility screening process is, at a minimum, a **TWO-STEP PROCESS**. The first step of the screening would be to determine (1) if the person is unable to transport his/her self or (2) if the person is unable to purchase transportation. Once this has been addressed, the next step is to establish why the person was unable to transport his/her self or unable to purchase transportation, based on the eligibility criteria approved by the Commission. The individual does not have to meet all of the criteria of the second step in order to be deemed eligible for non-sponsored transportation services.

Submit a completed application. Incomplete applications will be deemed as denied after 60 days from the date received, and your file will be closed. LeeTran will notify you about the status of your application.

For more information about the program, read LeeTran's Passport Passenger's Guide at https://www.leegov.com/leetran/passport-(ada-service)/eligibility. If you have any questions regarding this process, please contact the Passport office at the telephone number listed below.

Accessible formats are available upon request.

PASSPORT
a service of leetran

Lee County Transit – LeeTran Passport Services
3401 Metro Parkway
Fort Myers, FL 33901
Phone Number: (239) 533-0300
Fax Number: (239) 432-2035

Revised 1/5/23

Lee County Transit – LeeTran Passport Services
3401 Metro Parkway
Fort Myers, FL 33901
Phone Number: (239) 533-0300
Fax Number: (239) 432-2035

EMERGENCY CONTACT FORM

APPLICANT/PASSENGER'S NAME: _____

EMERGENCY CONTACT NAME: _____

RELATIONSHIP TO APPLICANT: _____

TELEPHONE NUMBER(S): _____

_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TRANSPORTATION DISADVANTAGED DETERMINATION FORM

All items must be completed and TYPED or PRINTED legibly or form will not be processed

SECTION I – IDENTIFYING INFORMATION

Last Name: _____ First Name: _____ M.I.___
Home Address: _____ Apt.# _____
Is this a: ☐ House ☐ Apartment ☐ Nursing Facility ☐ ACLF ☐ Boarding Home
City: _____ State: _____ Zip Code: _____
Date of Birth: _____/_____/_____ Your Current Age: _____ ☐ Male ☐ Female
Phone Number: (___)_____
Social Security Number: _____/_____/_____ Medicaid Number: _____
Total Monthly Income: _____ **(Must provide proof of household income)**

SECTION II – NEED DETERMINATION

Are you able to operate an automobile, even for short distances? ☐ Yes ☐ No
Do you or anyone in your household own a car? ☐ Yes ☐ No
What is your license plate(s) number(s)? _____ _____
_____ _____
Total # of persons who reside in your household? _____ Please list below:

Name	Is this person Related to you?	Does this person own own a car?
_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	☐ Yes ☐ No	☐ Yes ☐ No

If you live in an Assisted Care Living Facility, Nursing Home, ICFMR, or Boarding Home does this facility have a vehicle? ☐ Yes ☐ No
Have you ever been transported by the facility? ☐ Yes ☐ No
Do you have any family or friends who live in the County you reside in? ☐ Yes ☐ No
Has this person(s) ever transported you to the doctor? ☐ Yes ☐ No
Would this person(s) take you to the doctor if you asked them? ☐ Yes ☐ No
Do you know someone who would transport you if you paid for the gas? ☐ Yes ☐ No
Have you ever taken the LeeTran bus to the doctor or to other places? ☐ Yes ☐ No
Can you travel on a LeeTran bus? ☐ Yes ☐ No
If NO, please explain why:

_____
Would you use the LeeTran bus if you could ride for free? ☐ Yes ☐ No

Can you walk without help to the distances below? (Check those that apply)
☐ Across a room ☐ One block ☐ Two blocks ☐ Three blocks ☐ One mile

SECTION III – DISABILITY

Are you currently receiving Supplemental Security Income (SSI)? ☐ Yes ☐ No
Are you currently receiving Social Security Disability? ☐ Yes ☐ No
Do you consider yourself to be disabled? ☐ Yes ☐ No

If yes, what is the nature of your disability? (Check all that apply)
☐ Blind/Legally Blind ☐ Wheelchair User ☐ Difficulty Walking ☐ Arthritis
☐ Cerebral Palsy ☐ Multiple Sclerosis ☐ Neuromuscular Disease ☐ Stroke
☐ Alzheimer's Disease ☐ Epilepsy ☐ Respirator or Oxygen Dependent
☐ Muscular Dystrophy ☐ Mentally Challenged ☐ Emotionally Challenged
☐ Other (describe)
_____

Do you require mobility aids? ☐ Yes ☐ No
If YES, which aids do you require? Check all that apply?
☐ Walker ☐ Guide Dog ☐ Personal Care Attendant ☐ Scooter ☐ Cane ☐ Oxygen
☐ Wheelchair ☐ Other _____

SECTION IV – FREQUENCY OF USE/DESTINATIONS

What doctors or medical clinics do you visit on a regular basis?

NAME AND ADDRESS OF HOSPITAL, DOCTOR OR CLINIC	**NUMBER OF VISITS EACH MONTH OR WEEK**

SECTION V – SIGNATURE, PREPARER AND WITNESS

I affirm that the information provided in this application for services is true and correct and understand that making false statements, having others make false statements, or making false statements on behalf of others constitutes fraud and is considered **a felony under the laws of the State of Florida.**

Transportation Disadvantaged Recipient's

Signature: _____ Date: _____

Preparer's Signature: _____ Date: _____