

**Sarasota County Area Transit (SCAT)**  
**5303 Pinkney Avenue**  
**Sarasota, Florida 34233**  
**SCAT+Plus PROGRAM**

**OFFICIAL USE ONLY**

Received Date \_\_\_\_\_

Status \_\_\_\_\_

ID Card # \_\_\_\_\_

Expiration Date \_\_\_\_\_

(Door to door transportation for persons with disabilities unable to use the Fixed Route Bus)

**PART A: Application Profile** (PLEASE TYPE OR PRINT)

MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_

SSN \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Address \_\_\_\_\_ Gate Code/Password \_\_\_\_\_

Building or Complex Name \_\_\_\_\_ Number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Phone (Daytime) \_\_\_\_\_ Phone (Evening) \_\_\_\_\_

Primary Language Spoken: \_\_\_\_\_

Medicaid Number: \_\_\_\_\_

Please provide the name, telephone number and relationship of someone we can contact in the event of an emergency:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_

In case there was an order by Emergency Management for an Evacuation, would you need assistance to be evacuated?

Yes

No

If someone other than the applicant is filling out this application, please check the box and then enter the information below

I certify that the information provided in the application is true and correct based upon my own knowledge of the Applicant's health condition or disability.

Name of Assistant \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

**PART B: Disability and Mobility Information**

1. List the Disabling Condition(s) that prevent you from using the regular SCAT fixed route bus system and how this condition(s) would affect your use of the SCAT fixed route bus system:

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2. Which of the following mobility aids or equipment do you use to help you get where you need to go? (Please check all that apply to you)

- |  |   |
|--|---|
| <input type="checkbox"/> Cane  | <input type="checkbox"/> Manual Wheelchair    |
| <input type="checkbox"/> Long White Cane                                 | <input type="checkbox"/> Powered Wheelchair   |
| <input type="checkbox"/> Crutches  | <input type="checkbox"/> Powered Scooter/Cart |
| <input type="checkbox"/> Walker  | <input type="checkbox"/> Service Animal       |
| <input type="checkbox"/> Leg Braces                                      | <input type="checkbox"/> Alphabet Board       |
| <input type="checkbox"/> Portable Oxygen                                 | <input type="checkbox"/> Picture Board        |
| <input type="checkbox"/> Other _____                                     |   |
| <input type="checkbox"/> I do not use any of the above aids or equipment |   |

Please note that we can **not** accommodate wheelchairs/scooters that exceed these specifications \* (Please provide actual dimensions. If assistance is needed, please call 861-1038)

- 48 inches in length, \* (Actual Length is \_\_\_\_\_).
- 30 inches in width, \* (Actual Width is \_\_\_\_\_).
- 600 pounds (including the client)
- no extended leg
- footrest is required for each foot that you have

3. Do you require the assistance of a Personal Care Attendant (PCA) (someone who must assist you with daily life functions)?

- Yes                       No                       Occasionally

4. Is your condition(s) temporary?

- Yes -> How long do you expect it to last?    Years \_\_\_\_\_ Months \_\_\_\_\_
- No – Permanent -> How long have you had this condition or disability?
- Since birth     Years \_\_\_\_\_

**PART C: Transportation Information**

1. Have you ever used the regular SCAT bus?

Yes ->How many days per week? \_\_\_\_\_  
How many days per month? \_\_\_\_\_

Yes, I have used the bus, but stopped because \_\_\_\_\_  
\_\_\_\_\_

No

2. Do you know where your closest bus stop is located?

Yes ->How far from your house? \_\_\_\_\_

No \* (Note: If you reside more than 3/4 mile from nearest fixed route bus stop answer A). through D) below. Income verification is also required. Please submit a copy of your household tax return or similar document stating your annual household income).

A).What is your current mode of transportation:

\_\_\_\_\_

B). Are there any privately owned vehicles in your household? Yes\_\_\_, No\_\_\_

C). If Yes, How many? \_\_\_\_\_

D). Do you have family, friends, or neighbors that could assist with transportation? YES\_\_\_\_\_, NO\_\_\_\_\_

3. Please indicate below the reason(s) you are seeking SCATPLUS/ADA Para-transit eligibility. (Check all that apply)

I am able to ride the SCAT buses to go some places, but in other places I cannot get to and from the bus stops.

I am able to use SCAT fixed-route buses, but only if they are equipped with wheelchair lifts, kneelers and priority seating.

My disability prevents me from getting to the bus stop.

Other

\_\_\_\_\_  
\_\_\_\_\_

4. What might help you ride the regular SCAT buses? (Check all that apply)

Route and Schedule Information

Availability of Wheelchair Accessible Buses

A communication aid

Receiving training on how to use the SCAT buses

If the bus stops were closer to where I live and where I need to go

I can if the driver calls out the stops

Other\_\_\_\_\_

\_\_\_\_\_

5. Are you able to follow written or oral instructions to use the SCAT buses?  
 Yes                                       No (explain)                                       Occasionally (explain)

6. Using a mobility aid or on your own, how far can you walk or use a wheelchair?  
 I cannot get outside of my house or apartment  
 I can get to the curb in front of my house or apartment  
 I can walk or use a wheelchair up to 3 blocks  
 I can walk or use a wheelchair up to 6 blocks  
 I can walk or use a wheelchair up to 9 blocks  
 Over 9 blocks

7. Is your home ADA accessible (wheelchair ramp if needed, paved walkway, accessible doorway)?  
  
 Yes                                       No

8. Are there any other conditions, which limit your ability to use the regular SCAT fixed-route bus service?  
 Yes-> Please describe  
  
\_\_\_\_\_  
\_\_\_\_\_  
 No

**PART D: Current Travel Information**

1. Please list trips that you will make most frequently using the SCATPLUS/ADA Para-transit Shared Ride Service  
  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PART E: Travel Training**

1. SCAT offers free travel training to anyone interested in learning how to ride the SCAT fixed-route buses, would you be interested in getting information about this service?  
 Yes  
 No - > Explain \_\_\_\_\_  
 Already trained  
(Agency that trained you) \_\_\_\_\_

**PART F: Applicant's Certification**

SARASOTA COUNTY TRANSPORTATION AUTHORITY  
POLICY ON THE COLLECTION OF SOCIAL SECURITY NUMBERS

**Sarasota County Transportation Authority collects your Social Security number for the following purposes: Classification of accounts; identification and verification; credit worthiness; billing and payments; data collection, reconciliation, tracking, benefit processing, tax reporting, as a unique identifier and for search purposes.**

In compliance with the Americans with Disabilities Act of 1990 (ADA), SCAT provides Para-transit Shared Ride Service to anyone with a disability who cannot use the SCAT fixed-route bus service and who is traveling in Sarasota County. This service is commonly referred to as the SCAT PLUS Program. This application form is intended to determine when and under what circumstances the applicant can use the SCAT fixed route buses and when Para-transit Shared Ride Service is required.

I understand the purpose of the is application is to determine if I am eligible to use the SCAT ADA Para-transit service. I understand that my information contained in this application is kept confidential and shared only with professionals involved in evaluating my eligibility. I certify that, to the best of my knowledge, the information provided is correct. I authorize the licensed professional who provided professional verification, to release information relating to my disability in order for SCAT to assess eligibility determinations.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_  
(If someone other than the client is filling out this application, please sign above)

PLEASE BE ADVISED FAILURE TO COMPLETELY FILL OUT THIS APPLICATION WILL DELAY YOUR ELIGIBILITY PROCESS. IN ADDITION TO THIS FORM, A PHONE OR IN-PERSON INTERVIEW MAY BE REQUIRED. YOUR ELIGIBILITY WILL **NOT** BE DETERMINED WITHOUT ALL NECESSARY STEPS COMPLETED. SCAT PROVIDES ELIGIBILITY DETERMINATION IN WRITING WITHIN 21 DAYS OF THE COMPLETED APPLICATION PROCESS, WHICH INCLUDES THE CLIENT INTERVIEW.

**SCAT Plus Service Appeals**

**If you have been denied eligibility to the SCAT Plus door to door transportation service you may appeal the decision through an appeals process. To initiate the appeal please call SCAT Plus at 861-1018, or 851-1938 to submit your request for reconsideration in writing within 14 days of the receipt of your denial letter.**

WHEN COMPLETED, PLEASE RETURN THIS FROM TO:

**SARASOTA COUNTY AREA TRANSIT**

5303 PINKNEY AVENUE  
SARASOTA, FL 34233-2421  
(941) 861-1007 -- FAX

## **PART G: Professional Verification of Functional Abilities**

**Note: THIS PORTION MUST BE COMPLETED BY ONE OF THE FOLLOWING CURRENTLY LICENSED PROFESSIONALS:** Physician (M.D., D.O. or D.C.), Audiologist, Ophthalmologist, Psychologist, Registered Nurse, Physical Therapist

Dear Professional:

The American with Disabilities Act (ADA) of 1990 requires that Sarasota County Area Transit (SCAT) provide Para-transit Shared Ride Service to anyone who cannot use the regular SCAT fixed route bus service because of a disability.

The applicant who has asked you to review and sign this form is applying to SCAT to be considered for the ADA Para-transit Shared Ride Service. ADA Shared Ride Service is intended only for those trips that the applicant can not make on SCAT's fixed route service. This application form is intended to determine when and under what circumstances the applicant can use SCAT fixed route buses and when they require Para-transit Shared Ride Service.

The Sarasota County Area Transit bus system (SCAT) fleet is now fully equipped with wheelchair lifts and kneeling features making the fleet accessible to persons with disabilities.

Please note resources for this program are limited and your evaluation of each person must be based solely upon the individual's ability to use regular transit. ***Your verification should consider only the presence of a disabling condition***, not the applicant's age or economic status.

Thank you for your assistance

<p>FOR MORE INFORMATION CALL SCATPLUS PARATRANSIT CERTIFICATION OFFICE (941) 861-1018 FAX (941) 861-1007</p>
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(PLEASE TYPE OR PRINT CLEARLY RESPONSES TO ITEMS 1-5, SIGN AND COMPLETE ADDRESS AND CONTACT INFORMATION)

NAME OF APPLICANT: \_\_\_\_\_

1. Has the applicant been diagnosed with a cognitive, mental, physical, or other disability? *Please list all disabilities(NO DIAGNOSIS CODES PLEASE)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Please describe all conditions and their severity in detail.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. The Applicant's disability is:

- Permanent  
 Temporary -> Expected Duration? Years \_\_\_\_\_ Months \_\_\_\_\_

4. On sensory or cognitive impairments, is the applicant able to: Please check Yes or No

- Communicate addresses, destinations, and telephone numbers upon request \_\_Y\_\_N  
Ask for, understand and follow directions \_\_Y\_\_N  
Recognize a destination or landmark \_\_Y\_\_N  
Deal with unexpected situations or changes in routine \_\_Y\_\_N  
Safely and effectively travel through crowded and or complex facilities \_\_Y\_\_N

5. Does the Applicant require assistance of a Personal Care Attendant (PCA) when traveling on a public vehicle?

- Yes  
 No

Signature: \_\_\_\_\_

Print or Type Name and Title: \_\_\_\_\_

State of Florida Medical License No: \_\_\_\_\_

Business Name: \_\_\_\_\_

Business Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ FAX: \_\_\_\_\_

Date: \_\_\_\_\_