Florida Commission for the Transportation Disadvantaged

Transportation Disadvantaged Trip & Equipment Grant Application Form

Legal Name	Broward County Florida		
Federal Employer Identification Number	59-6000531-037		
Registered Address	1 N. University Drive		
City and State	Plantation, FL	Zip Code	33324
Contact Person for this Grant	Paul Strobis	Phone Number *Format 111-111-1111*	954-357-8321
E-Mail Address *[Required]*	pstrobis@broward.org		
Project Location *[County(ies)]*	Broward	Proposed Project Start Date	7/1/2019

Budget Allocation	
Grant Amount – State Allocation [90%]	$4,638,009.00
Grant Amount – Local Match [10%]	$515,334.00
Grant Amount – Proviso [90%]	0
Grant Amount – Proviso Match [10%]	0
Voluntary Dollar Amount	$788.00
Local Match for Voluntary Dollars [In Kind]	$88.00
Total Project Amount	**$5,154,219.00**

Capital Equipment Request	
Description of Capital Equipment	$ Amount
Total Project Amount	**$ 0.00**

Local Coordinating Board Review IS Required if Requesting Capital Equipment

If the purchase of capital equipment is included in this Application Form, the application has been reviewed by the _____ Local Coordinating Board.

_____ _____

Signature of Local Coordinating Board Chairperson ***Date***

I, the authorized Grantee Representative, hereby certify that the information contained in this form is true and accurate and is submitted in accordance with the 2019-20 Program Manual and Application for the Trip & Equipment Grant.

_____ _____

Signature of Grant Recipient Representative ***Date***

Florida Commission for the Transportation Disadvantaged

Transportation Disadvantaged Trip & Equipment Grant Service Rates Form

Applicant	Broward County Florida
Project Location [County(ies)]	Broward
Service Rate Effective Date	July 1, 2019

Grant Agreement Service Rates		
Type of Service Transportation Mode	Unit of Measure (Trip or Passenger Mile)	Cost Per Unit
* Ambulatory	Trip	18.80
* Wheel Chair	Trip	32.22
* Stretcher		
Bus Pass – Daily	Pass	
Bus Pass – Weekly	Pass	
Bus Pass – Monthly	Pass	
Reduced Fare Bus Pass - Monthly	Pass	40.00
Regular Fare Bus Pass- Monthly	Pass	70.00

**** Ambulatory, Wheel Chair and Stretcher*** must all use the *same Unit of Measure* either ***Trip or Passenger Mile***;
Cannot mix, all must be the same regardless of Transportation Mode.

Florida Commission for the Transportation Disadvantaged

TRANSPORTATION DISADVANTAGED TRIP & EQUIPMENT GRANT STANDARD ASSURANCES

The Grantee hereby assures and certifies that:

1. The Grantee has the requisite fiscal, managerial, and legal capacity to carry out the Transportation Disadvantaged Program and to receive and disburse State funds.

2. The Grantee is aware that the Trip & Equipment Grant is a reimbursement grant. Reimbursement of funds will be approved for payment upon receipt of a properly completed invoice with supporting documentation.

3. Trip & Equipment Grant funds will not be used to supplant or replace existing federal, state, or local government funds.

4. The Grantee understands that an approved written eligibility application and eligibility support documentation is required and is to be maintained for each rider who receives a non-sponsored trip or bus pass and such documentation shall be made available upon request by CTD staff or its designee.

5. The Grantee is aware that if capital equipment is purchased with these grant funds, equipment must be received by the recipient no later than June 30, 2020.

6. The Grantee recipient is aware that the approved project must be complete by June 30, 2020, which means services must be provided by that date or reimbursement will not be approved.

7. Capital equipment purchased through this grant shall comply with the recipient's competitive procurement requirements or Chapter 287 or Chapter 427, Florida Statutes.

This certification is valid for the agreement period for which the grant application is filed.

Signature: _____ Date: _____
Name: Bertha Henry
Title: County Administrator
Agency: Broward County Florida
Service Area: Broward County, FL

Preliminary Information Worksheet

Version 1.4

CTC Name:	Broward County
County (Service Area):	Broward County
Contact Person:	Paul Strobis
Phone #	954-357-8321

Check Applicable Characteristic:

ORGANIZATIONAL TYPE:		**NETWORK TYPE:**	
◉	Governmental	○	Fully Brokered
○	Private Non-Profit	◉	Partially Brokered
○	Private For Profit	○	Sole Source

Once completed, proceed to the Worksheet entitled "Comprehensive Budget"

Comprehensive Budget Worksheet

Version 1.4

CTC: **Broward County**
County: **Broward County**

*1. Complete applicable **GREEN** cells in columns 2, 3, 4, and 7*

	Prior Year's **ACTUALS** from Oct 1st of **2017** to Sept 30th of **2018**	Current Year's **APPROVED** Budget, **as amended** from Oct 1st of **2018** to Sept 30th of **2019**	Upcoming Year's **PROPOSED** Budget from Oct 1st of **2019** to Sept 30th of **2020**	% Change from Prior Year to Current Year	Proposed % Change from Current Year to Upcoming Year	Confirm whether revenues are collected as a system subsidy VS a purchase of service at a unit price. Explain Changes in Column 6 That Are > ± 10% and Also > ± $50,000
1	2	3	4	5	6	7
REVENUES (CTC/Operators ONLY / Do **NOT** include coordination contractors!)						
Local Non-Govt						
Farebox						
Medicaid Co-Pay Received						
Donations/ Contributions						
In-Kind, Contributed Services						
Other						
Bus Pass Program Revenue						
Local Government						
District School Board						
Compl. ADA Services	$ 20,602,932	$ 22,003,254	$ 24,443,464	6.8%	11.1%	
County Cash	$ 432,228	$ 492,288	$ 515,334	13.9%	4.7%	
County In-Kind, Contributed Services						
City Cash						
City In-kind, Contributed Services						
Other Cash						
Other In-Kind, Contributed Services						
Bus Pass Program Revenue						
CTD						
Non-Spons. Trip Program	$ 3,890,998	$ 4,430,595	$ 4,638,797	13.9%	4.7%	Other TD funds was 1 year Planning Grant
Non-Spons. Capital Equipment						
Rural Capital Equipment						
Other TD (specify in explanation)		$ 59,893			-100.0%	
Bus Pass Program Revenue						
USDOT & FDOT						
49 USC 5307						
49 USC 5310						
49 USC 5311 (Operating)						
49 USC 5311(Capital)						
Block Grant						
Service Development						
Commuter Assistance						
Other DOT (specify in explanation)						
Bus Pass Program Revenue						
AHCA						
Medicaid						
Other AHCA (specify in explanation)						
Bus Pass Program Revenue						
DCF						
Alcoh, Drug & Mental Health						
Family Safety & Preservation						
Comm. Care Dis./Aging & Adult Serv.						
Other DCF (specify in explanation)						
Bus Pass Program Revenue						
DOH						
Children Medical Services						
County Public Health						
Other DOH (specify in explanation)						
Bus Pass Program Revenue						
DOE (state)						
Carl Perkins						
Div of Blind Services						
Vocational Rehabilitation						
Day Care Programs						
Other DOE (specify in explanation)						
Bus Pass Program Revenue						
AWI						
WAGES/Workforce Board						
Other AWI (specify in explanation)						
Bus Pass Program Revenue						
DOEA						
Older Americans Act						
Community Care for Elderly						
Other DOEA (specify in explanation)						
Bus Pass Program Revenue						
DCA						
Community Services						
Other DCA (specify in explanation)						
Bus Pass Admin. Revenue						

Comprehensive Budget Worksheet

Version 1.4

CTC: **Broward County**
County: **Broward County**

1. *Complete applicable* ***GREEN*** *cells in columns 2, 3, 4, and 7*

	Prior Year's **ACTUALS** from Oct 1st of **2017** to Sept 30th of **2018**	Current Year's **APPROVED** Budget, **as amended** from Oct 1st of **2018** to Sept 30th of **2019**	Upcoming Year's **PROPOSED** Budget from Oct 1st of **2019** to Sept 30th of **2020**	% Change from Prior Year to Current Year	Proposed % Change from Current Year to Upcoming Year	Confirm whether revenues are collected as a system subsidy VS a purchase of service at a unit price. Explain Changes in Column 6 That Are > ± 10% and Also > ± $50,000
1	2	3	4	5	6	7
APD						
Office of Disability Determination						
Developmental Services						
Other APD (specify in explanation)						
Bus Pass Program Revenue						
DJJ						
(specify in explanation)						
Bus Pass Program Revenue						
Other Fed or State						
xxx						
xxx						
xxx						
Bus Pass Program Revenue						
Other Revenues						
Interest Earnings						
xxxx						
xxxx						
Bus Pass Program Revenue						
Balancing Revenue to Prevent Deficit						
Actual or Planned Use of Cash Reserve						
Balancing Revenue is Short By =		None	None			
Total Revenues =	**$24,926,158**	**$26,986,030**	**$29,597,595**	**8.3%**	**9.7%**	
EXPENDITURES (CTC/Operators ONLY / Do **NOT** include Coordination Contractors!)						
Operating Expenditures						
Labor	$ 707,738	$ 705,150	$ 726,305	-0.4%	3.0%	
Fringe Benefits	$ 216,525	$ 230,350	$ 237,261	6.4%	3.0%	
Services	$ 2,125,371	$ 1,920,000	$ 2,547,188	-9.7%	32.7%	
Materials and Supplies	$ 171,021	$ 139,700	$ 188,112	-18.3%	34.7%	
Utilities						
Casualty and Liability						
Taxes						
Purchased Transportation:						
Purchased Bus Pass Expenses						
School Bus Utilization Expenses						
Contracted Transportation Services	$ 21,629,458	$ 23,895,830	$ 25,727,730	10.5%	7.7%	
Other	$ 76,045	$ 95,000	$ 171,000	24.9%	80.0%	
Miscellaneous						
Operating Debt Service - Principal & Interest						
Leases and Rentals						
Contrib. to Capital Equip. Replacement Fund						
In-Kind, Contributed Services	$ -	$ -	$ -			
Allocated Indirect						
Capital Expenditures						
Equip. Purchases with Grant Funds						
Equip. Purchases with Local Revenue						
Equip. Purchases with Rate Generated Rev.						
Capital Debt Service - Principal & Interest						
	$0					
Total Expenditures =	**$24,926,158**	**$26,986,030**	**$29,597,595**	8.3%	9.7%	

See NOTES Below.

Once completed, proceed to the Worksheet entitled "Budgeted Rate Base"

ACTUAL year GAIN (program revenue) MUST be reinvested as a trip or system subsidy. Adjustments must be Identified and explained in a following year, or applied as a Rate Base Adjustment to proposed year's rates on the next sheet.

Budgeted Rate Base Worksheet

Version 1.4

CTC: **Broward County**

County: **Broward County**

1. *Complete applicable **GREEN** cells in column 3; **YELLOW** and **BLUE** cells are automatically completed in column 3*
2. *Complete applicable **GOLD** cells in column and 5*

	Upcoming Year's **BUDGETED** Revenues from Oct 1st of **2019** to Sept 30th of **2020**	What amount of the Budgeted Revenue in col. 2 will be generated at the rate per unit determined by this spreadsheet, OR used as local match for these type revenues?	Budgeted Rate Subsidy Revenue **EX**cluded from the Rate Base	What amount of the Subsidy Revenue in col. 4 will come from funds to purchase equipment, OR will be used as match for the purchase of equipment?	
	1	3	4	5	
REVENUES (CTC/Operators ONLY)					
Local Non-Govt					
Farebox	$ -		$ -		
Medicaid Co-Pay Received	$ -		$ -		
Donations/ Contributions	$ -		$ -		
In-Kind, Contributed Services	$ -	$ -	$ -		
Other	$ -		$ -		
Bus Pass Program Revenue	$ -	$ -	$ -		
Local Government					
District School Board	$ -	$ -	$ -		
Compl. ADA Services	$ 24,443,464	$ -	$ 24,443,464		
County Cash	$ 515,334		$ 515,334		
County In-Kind, Contributed Services	$ -	$ -	$ -		
City Cash	$ -		$ -		
City In-kind, Contributed Services	$ -	$ -	$ -		
Other Cash	$ -		$ -		
Other In-Kind, Contributed Services	$ -	$ -	$ -		
Bus Pass Program Revenue	$ -	$ -	$ -		
CTD					local match req.
Non-Spons. Trip Program	$ 4,638,797	$ 4,638,797	$ -	$ -	$ 515,422
Non-Spons. Capital Equipment	$ -	$ -	$ -	$ -	$ -
Rural Capital Equipment	$ -	$ -	$ -	$ -	$ -
Other TD	$ -		$ -		
Bus Pass Program Revenue	$ -	$ -	$ -		
USDOT & FDOT					
49 USC 5307	$ -	$ -	$ -		
49 USC 5310	$ -	$ -	$ -	$ -	$ -
49 USC 5311 (Operating)	$ -		$ -		
49 USC 5311(Capital)	$ -	$ -	$ -	$ -	$ -
Block Grant	$ -	$ -	$ -		
Service Development	$ -	$ -	$ -		
Commuter Assistance	$ -	$ -	$ -		
Other DOT	$ -		$ -		
Bus Pass Program Revenue	$ -	$ -	$ -		
AHCA					
Medicaid	$ -	$ -	$ -		
Other AHCA	$ -		$ -		
Bus Pass Program Revenue	$ -	$ -	$ -		
DCF					
Alcoh, Drug & Mental Health	$ -	$ -	$ -		
Family Safety & Preservation	$ -	$ -	$ -		
Comm. Care Dis./Aging & Adult Serv.	$ -	$ -	$ -		
Other DCF	$ -		$ -		
Bus Pass Program Revenue	$ -	$ -	$ -		
DOH					
Children Medical Services	$ -	$ -	$ -		
County Public Health	$ -	$ -	$ -		
Other DOH	$ -		$ -		
Bus Pass Program Revenue	$ -	$ -	$ -		
DOE (state)					
Carl Perkins	$ -	$ -	$ -		
Div of Blind Services	$ -	$ -	$ -		
Vocational Rehabilitation	$ -	$ -	$ -		
Day Care Programs	$ -	$ -	$ -		
Other DOE	$ -		$ -		
Bus Pass Program Revenue	$ -	$ -	$ -		
AWI					
WAGES/Workforce Board	$ -	$ -	$ -		
AWI	$ -		$ -		
Bus Pass Program Revenue	$ -	$ -	$ -		
DOEA					
Older Americans Act	$ -	$ -	$ -		
Community Care for Elderly	$ -	$ -	$ -		
Other DOEA	$ -		$ -		
Bus Pass Program Revenue	$ -	$ -	$ -		
DCA					
Community Services	$ -	$ -	$ -		
Other DCA	$ -		$ -		
Bus Pass Program Revenue	$ -	$ -	$ -		

YELLOW cells
are NEVER Generated by Applying Authorized Rates

BLUE cells
Should be funds generated by rates in this spreadsheet

GREEN cells
MAY BE Revenue Generated by Applying Authorized Rate per Mile/Trip Charges

Fill in that portion of budgeted revenue in Column 2 that will be GENERATED through the application of authorized per mile, per trip, or combination per trip plus per mile rates. Also, include the amount of funds that are Earmarked as local match for Transportation Services and NOT Capital Equipment purchases.

If the Farebox Revenues are used as a source of Local Match Dollars, then identify the appropriate amount of Farebox Revenue that represents the portion of Local Match required on any state or federal grants. This does not mean that Farebox is the only source for Local Match.

Please review all Grant Applications and Agreements containing State and/or Federal funds for the proper Match Requirement levels and allowed sources.

GOLD cells

Fill in that portion of Budgeted Rate Subsidy Revenue in Column 4 that will come from Funds Earmarked by the Funding Source for Purchasing Capital Equipment. Also include the portion of Local Funds earmarked as Match related to the Purchase of Capital Equipment if a match amount is required by the Funding Source.

Budgeted Rate Base Worksheet

Version 1.4

CTC: **Broward County**

County: **Broward County**

1. *Complete applicable **GREEN** cells in column 3; **YELLOW** and **BLUE** cells are automatically completed in column 3*
2. *Complete applicable **GOLD** cells in column and 5*

	Upcoming Year's **BUDGETED** Revenues from Oct 1st of **2019** to Sept 30th of **2020**	What amount of the Budgeted Revenue in col. 2 will be generated at the rate per unit determined by this spreadsheet, OR used as local match for these type revenues?	Budgeted Rate Subsidy Revenue **EX**cluded from the Rate Base	What amount of the Subsidy Revenue in col. 4 will come from funds to purchase equipment, OR will be used as match for the purchase of equipment?
	1	**3**	**4**	**5**
APD				
Office of Disability Determination	$ -	$ -	$ -	
Developmental Services	$ -	$ -	$ -	
Other APD	$ -		$ -	
Bus Pass Program Revenue	$ -	$ -	$ -	
DJJ				
DJJ	$ -		$ -	
Bus Pass Program Revenue	$ -	$ -	$ -	
Other Fed or State				
xxx	$ -		$ -	
xxx	$ -		$ -	
xxx	$ -		$ -	
Bus Pass Program Revenue	$ -	$ -	$ -	
Other Revenues				
Interest Earnings	$ -	$ -	$ -	
xxxx	$ -		$ -	
xxxx	$ -		$ -	
Bus Pass Program Revenue	$ -	$ -	$ -	
Balancing Revenue to Prevent Deficit				
Actual or Planned Use of Cash Reserve	$ -	$ -	$ -	
Total Revenues =	**$ 29,597,595**	**$ 4,638,797**	**$ 24,958,798**	**$ -**

EXPENDITURES (CTC/Operators ONLY)

Operating Expenditures	
Labor	$ 726,305
Fringe Benefits	$ 237,261
Services	$ 2,547,188
Materials and Supplies	$ 188,112
Utilities	$ -
Casualty and Liability	$ -
Taxes	$ -
Purchased Transportation:	
Purchased Bus Pass Expenses	$ -
School Bus Utilization Expenses	$ -
Contracted Transportation Services	$ 25,727,730
Other	$ 171,000
Miscellaneous	$ -
Operating Debt Service - Principal & Interest	$ -
Leases and Rentals	$ -
Contrib. to Capital Equip. Replacement Fund	$ -
In-Kind, Contributed Services	$ -
Allocated Indirect	$ -
Capital Expenditures	
Equip. Purchases with Grant Funds	$ -
Equip. Purchases with Local Revenue	$ -
Equip. Purchases with Rate Generated Rev.	$ -
Capital Debt Service - Principal & Interest	$ -
	$ -
Total Expenditures =	**$ 29,597,595**
minus **EXCLUDED** Subsidy Revenue =	$ 24,958,798
Budgeted Total Expenditures **INCLUDED** in Rate Base =	$ 4,638,797
Rate Base Adjustment[1] =	
Adjusted Expenditures Included in Rate Base =	**$ 4,638,797**

$ 24,958,798

Amount of Budgeted Operating Rate Subsidy Revenue

$

[1] Rate Base Adjustment Cell

If necessary and justified, this cell is where you could optionally adjust proposed service rates up or down to adjust for program revenue (or unapproved profit), or losses from the Actual period shown at the bottom of the Comprehensive Budget Sheet. This is not the only acceptable location or method of reconciling for excess gains or losses. If allowed by the respective funding sources, excess gains may also be adjusted by providing system subsidy revenue or by the purchase of additional trips in a period following the Actual period. If such an adjustment has been made, provide notation in the respective exlanation area of the Comprehensive Budget tab.

[1] The Difference between Expenses and Revenues for Fiscal Year: **2017 - 2018**

Once Completed, Proceed to the Worksheet entitled "Program-wide Rates"

Worksheet for Program-wide Rates

CTC: **Broward County** Version 1.4
County: **Broward County**

*1. Complete Total Projected Passenger Miles and ONE-WAY Passenger Trips (**GREEN** cells) below*

Do NOT include trips or miles related to Coordination Contractors!
Do NOT include School Board trips or miles UNLESS…….
INCLUDE all ONE-WAY passenger trips and passenger miles related to services you purchased from your transportation operators!
Do NOT include trips or miles for services provided to the general public/private pay UNLESS..
Do NOT include escort activity as passenger trips or passenger miles unless charged the full rate for service!
Do NOT include fixed route bus program trips or passenger miles!

PROGRAM-WIDE RATES

Total Projected **Passenger** Miles =	3,217,532
Rate Per Passenger Mile =	**$ 1.44**
Total Projected **Passenger** Trips =	215,942
Rate Per Passenger Trip =	**$ 21.48**

Fiscal Year

2019 - 2020

Avg. Passenger Trip Length = 14.9 Miles

Rates If No Revenue Funds Were Identified As Subsidy Funds

Rate Per Passenger Mile =	**$ 9.20**
Rate Per Passenger Trip =	**$ 137.06**

Once Completed, Proceed to the Worksheet entitled "Multiple Service Rates"

Vehicle Miles
The miles that a vehicle is scheduled to or actually travels from the time it pulls out from its garage to go into revenue service to the time it pulls in from revenue service.

Vehicle Revenue Miles (VRM)
The miles that vehicles are scheduled to or actually travel while in revenue service. Vehicle revenue miles exclude:

Deadhead
Operator training, and
Vehicle maintenance testing, as well as
School bus and charter services.

Passenger Miles (PM)
The cumulative sum of the distances ridden by each passenger.

Worksheet for Multiple Service Rates

CTC: **Broward County** Version 1.4
County: **Broward County**

1. Answer the questions by completing the GREEN cells starting in Section I for all services
2. Follow the DARK RED prompts directing you to skip or go to certain questions and sections based on previous answers

SECTION I: Services Provided

	Ambulatory	Wheelchair	Stretcher	Group
1. Will the CTC be providing any of these Services to transportation disadvantaged passengers in the upcoming budget year?.....	(●) Yes ( ) No	(●) Yes ( ) No	( ) Yes (●) No	( ) Yes (●) No
	Go to Section II for Ambulatory Service	Go to Section II for Wheelchair Service	STOP! Do NOT Complete Sections II - V for Stretcher Service	STOP! Do NOT Complete Sections II - V for Group Service

SECTION II: Contracted Services

	Ambulatory	Wheelchair	Stretcher	Group
1. Will the CTC be contracting out any of these Services TOTALLY in the upcoming budget year?....	(●) Yes ( ) No	(●) Yes ( ) No	( ) Yes (●) No	( ) Yes (●) No
	Answer # 2 for Ambulatory Service	Answer # 2 for Wheelchair Service	Do Not Complete Section II for Stretcher Service	Do Not Complete Section II for Group Service
2. If you answered YES to #1 above, do you want to arrive at the billing rate by simply dividing the proposed contract amount by the projected Passenger Miles / passenger trips?.....	( ) Yes (●) No	( ) Yes (●) No	( ) Yes (●) No	( ) Yes (●) No
	Leave Blank	Leave Blank	Do NOT Complete Section II for Stretcher Service	Do NOT Complete Section II for Group Service
3. If you answered YES to #1 & #2 above, how much is the proposed contract amount for the service?				
How many of the total projected Passenger Miles relate to the contracted service?				
How many of the total projected passenger trips relate to the contracted service?				
Effective Rate for **Contracted Services:**	Ambulatory	Wheelchair	Stretcher	Group
per **Passenger Mile** =				
per **Passenger Trip** =				
	Go to Section III for Ambulatory Service	Go to Section III for Wheelchair Service	Do NOT Complete Section II for Stretcher Service	Do NOT Complete Section II for Group Service
4. If you answered # 3 & want a Combined Rate per Trip PLUS a per Mile add-on for 1 or more services, INPUT the Desired per Trip Rate (but must be less than per trip rate in #3 above =	Combination Trip and Mile Rate			
Rate per Passenger Mile for Balance =				
	Leave Blank and Go to Section III for Ambulatory Service	Leave Blank and Go to Section III for Wheelchair Service	Do NOT Complete Section II for Stretcher Service	Do NOT Complete Section II for Group Service

Worksheet for Multiple Service Rates

CTC: **Broward County** Version 1.4
County: **Broward County**

1. Answer the questions by completing the GREEN cells starting in Section I for all services
2. Follow the DARK RED prompts directing you to skip or go to certain questions and sections based on previous answers

SECTION III: Escort Service

1. Do you want to charge all escorts a fee?..... ○ Yes ◉ No
   Skip #2 - 4 and Section IV and Go to Section V
2. If you answered Yes to #1, do you want to charge the fee per passenger trip OR ..... ◉ Pass. Trip ○ Pass. Mile — **Leave Blank**
   per passenger mile?.....
3. If you answered Yes to # 1 and completed # 2, for how many of the projected Passenger Trips / Passenger Miles will a passenger be accompanied by an escort? — Leave Blank
4. How much will you charge each escort?..... — Leave Blank

SECTION IV: Group Service Loading

1. If the message "You Must Complete This Section" appears to the right, what is the projected total number of Group Service Passenger Miles? (otherwise leave blank)..... — **Do NOT Complete Section IV**

..... And what is the projected total number of Group Vehicle Revenue Miles?

Loading Rate **0.00** to 1.00

SECTION V: Rate Calculations for Mulitple Services:

1. Input Projected Passenger Miles and Passenger Trips for each Service in the GREEN cells and the Rates for each Service will be calculated automatically
   * Miles and Trips you input must sum to the total for all Services entered on the "Program-wide Rates" Worksheet, MINUS miles and trips for contracted services IF the rates were calculated in the Section II above
   * Be sure to leave the service BLANK if you answered NO in Section I or YES to question #2 in Section II

RATES FOR FY: 2019 - 2020

	Ambul	Wheel Chair	Stretcher	Group	
			Leave Blank	Leave Blank	
Projected Passenger Miles (excluding totally contracted services addressed in Section II) = 3,217,532 =	2,574,026 +	643,506 +	+	0	
Rate per Passenger Mile =	**$1.26**	**$2.16**	**$0.00**	**$0.00** per passenger	**$0.00** per group

	Ambul	Wheel Chair	Stretcher	Group	
			Leave Blank	Leave Blank	
Projected Passenger Trips (excluding totally contracted services addressed in Section II) = 215,942 =	172,753 +	ptions +	+	+	
Rate per Passenger Trip =	**#VALUE!**	**#VALUE!**	**$0.00**	**$0.00** per passenger	**$0.00** per group

Does Not = Total Projected Passenger Trips, with adjmt. for contracted services

2 If you answered # 1 above and want a COMBINED Rate per Trip PLUS a per Mile add-on for 1 or more services,...

Combination Trip and Mile Rate

	Ambul	Wheel Chair	Stretcher	Group	
			Leave Blank	Leave Blank	
...INPUT the Desired Rate per Trip (but must be less than per trip rate above) =					$0.00
Rate per Passenger Mile for Balance =	**$1.26**	**#VALUE!**	**$0.00**	**$0.00** per passenger	**$0.00** per group

#VALUE! #VALUE!

Rates If No Revenue Funds Were Identified As Subsidy Funds

	Ambul	Wheel Chair	Stretcher	Group	
Rate per Passenger Mile =	**$8.05**	**$13.80**	**$0.00**	**$0.00** per passenger	**$0.00** per group
Rate per Passenger Trip =	**#VALUE!**	**#VALUE!**	**#VALUE!**	**#VALUE!** per passenger	**#VALUE!** per group

Program These Rates Into Your Medicaid Encounter Data

TRANSPORTATION DISADVANTAGED (TD) DOOR-TO-DOOR PROGRAM

Dear TOPS! Applicant:

Thank you for your interest in TOPS! The Florida Commission for Transportation Disadvantaged (TD) program is one of the transportation programs provided by TOPS!

Door-to-Door Paratransit Transportation: Shared-ride paratransit transportation is provided to eligible Broward County residents with physical, cognitive, emotional, visual, or other disabilities which functionally prevent them from using the BCT fixed-route bus system permanently, temporarily or under certain conditions. Door-to-door paratransit transportation is provided to health care, employment, education, shopping, social activities and other life-sustaining activities.

Eligibility: The TD program is a "last resort" program for disabled individuals in need of transportation and do not have access to any other transportation resource**.** TD eligibility criteria requires the applicant to qualify under **both disability AND current Federal Poverty Level Guidelines**, depending on the number of family members in household, at the 225 percent level. *(see chart below)* We are required to make every effort to verify your income and medical information to determine eligibility. Blanks on your application are considered as incomplete and may affect the timeliness of eligibility determination.

Persons in family/household	225% of 2019 Federal Poverty Guidelines
1	$ 28,102.50
2	$ 38,047.50
3	$ 47,992.50

For households of more than three members please view our website at www.broward.org/bct to access the complete TD Income Guidelines chart.

Completed TD applications must contain all requested information. You are required to submit identification and applicable financial supporting documents when submitted. Self-declaration of income is not accepted. Faxed or Emailed applications are not accepted due to the collection of individually identifiable information**.**

Complete application information prior to printing and submitting.

Mail to: Paratransit Eligibility Services
Broward County Transit
1 N. University Dr., Suite 2400-B
Plantation, FL 33324
Information: 954-357-8400
(Mail or hand deliver application to the above address)

NOTICE OF COLLECTING SOCIAL SECURITY NUMBER (SSN) FOR GOVERNMENT PURPOSE
Broward County collects SSNs for different purposes. The Florida Public Records Law, Section 119.071(5), F.S. (2007) requires County to give you this written statement explaining the purpose and authority for collecting your SSN.

FORM	PURPOSE	AUTHORIZATION
TD Application	Conduct eligibility verification and monitor for system abuse	County policy (See Note)

NOTE: Broward County collects your SSN in the performance of a duty or responsibility County must complete in accordance with law or business necessity. In the event a law does not specifically provide County with the authority to collect your SSN, it is imperative County collect your SSN and this is expressly provided in section 119.081 (5) 2.b.

Transportation Disadvantaged Application
DOOR-TO-DOOR PARATRANSIT SERVICES
Broward County Transit

Office Use Only
Client ID: _____
Date Approved: _____
Date Denied: _____

Instructions:
Complete Sections 1 and 2. Section 3 must be completed by a Florida Licensed Physician. Attach all required documentation. Self-declaration of income is not accepted.

A copy of your Current Florida Driver's License / Florida ID Showing a Broward County address is required.

SECTION 1 – GENERAL INFORMATION (PLEASE PRINT LEGIBLY)

Name of Applicant:	Phone:
Home Address:	
Mailing Address (if different):	
If using agency to receive mail, provide agency letter stating they will receive your mail	
Is a vehicle registered in your name? YES ☐ NO ☐ Do you drive? YES ☐ NO ☐	
Date of Birth:	Social Security Number:
Are you receiving Medicaid? YES ☐ NO ☐	If YES, Medicaid #:
Emergency Contact:	Phone:
Number of ***relatives***, including self, living in household: _____	Enter Total Annual Household Income Here (**lines 1 through 8 below**): _____

For us to determine your household income, please submit a copy of all current annual income/benefit(s) received by you and/or any relative(s) living in the residence.*

1. Most recent pay stub with year-to-date reporting $_____
2. DCF Benefits / Cash Assist. / Food Stamps with benefit amount $_____
3. Unemployment Compensation $_____
4. Social Security Awards Letter (SSA / SSI / SSDI) $_____
5. Retirement / Pension / Investment $_____
6. Disabled Veteran Benefits $_____
7. Housing benefits (HUD, Section 8) *(Not Happy Choice Voucher)* $_____
8. Other (Specify) $_____

Self Declarations are not accepted as proof of lack of income.

***If $0 income, and you live in a house or apartment, indicate how rent / utilities are paid (this includes balance remaining after rent subsidy).**

Additional documentation may be required to support household income.

(OVER)

SECTION 1 – GENERAL INFORMATION (CONTINUED) (PLEASE PRINT LEGIBLY)

VETERAN'S INFORMATION

Are you a United States veteran? YES ____ NO ____

If YES, type of Military Discharge:

Honorable ____ General (Honorable Conditions) ____

If YES, attach Proof of Honorable Discharge.

Need a copy of your Discharge?
Contact Broward County Elderly and Veterans Services by calling 954-357-6622.

SECTION 2 – HOUSEHOLD MEMBERS (RELATIVES)

NAME	DATE OF BIRTH	RELATIONSHIP	SOCIAL SECURITY NUMBER

Did you attach a copy of your FL ID or Drivers license? Yes _____ No _____
Did you attach all required documents? Yes _____ No _____
Is the Medical Form completed by a Florida Licensed Physician? Yes____ No ____

I attest all information is correct and if there are any changes, I will report them to TOPS! Paratransit Services immediately. **(DO NOT E-MAIL OR FAX)**

_____ _____
Signature of Applicant Date

_____ _____
Signature of Preparer (if other than applicant) Date

_____ _____
Print Name (Preparer) Relationship

Return to: Broward County Transit - Paratransit Services Eligibility
1 N University Dr., 2400 - B, Plantation, FL 33324
(Mail or hand deliver application to the above address)

Transportation Disadvantaged Application
Door-To-Door Paratransit Service
Broward County Transit
Section 3 – MEDICAL

Client ID: _____

Applicant Name: _____ Date of Birth: _____

SECTION 3 – MEDICAL (TO BE COMPLETED BY FLORDIA LICENSED PHYSICIAN)

Does applicant have Medicaid? Yes ____ No ____ If Yes, Medicaid #: _____

Medicaid Program Code: _____

Indicate Mobility Aides / Equipment / Disability Condition(s):

Mobility Aides / Equipment:

Crutches ___ Scooter ___ W/C ___ PWR W/C ___ Walker ___ Cane ___ Leg Brace ___

Back Brace ___ AMBI ___ None ___ O2 Tank ___ Other _____

Disability Condition(s):

Functional ___ Hearing ___ Visual ___ Cognitive ___

Please explain below how the applicant's disability stops the applicant from independently using the BCT fixed-route bus? *(BCT Buses are 100% handicapped accessible).*

_____

_____

_____

_____

I, the undersigned, certify the medical information provided on this 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.

_____ _____
Physician's Signature Florida Medical License Number

_____ _____
Physician's Name (Print Legibly) Contact Number

TRANSPORTATION DISADVANTAGED (TD) BUS PASS PROGRAM

Dear TOPS! Applicant:

Thank you for your interest in TOPS! The Florida Commission for Transportation Disadvantaged (TD) program is one of the transportation programs provided by TOPS! The TD bus pass program is for eligible Broward County residents who are unable to use Broward County Transit's (BCT) fixed-route bus service as a result of having low income.

Bus Pass Program: A 31-day BCT fixed-route bus pass is provided to Broward residents at no charge. Eligible recipients receive bus passes via U. S. mail only. TD bus passes cannot be picked-up at County facilities.

Eligibility: The TD program is a "last resort" program for individuals in need of transportation and do not have access to any other transportation resource**.** We are required to make every effort to verify your income to determine eligibility. Blanks on your application are considered as incomplete and may affect the timeliness of eligibility determination. TD services require the applicant to qualify under current Federal Poverty Level Guidelines, depending on the number of family members in household, at the 225 percent level. *(see chart below)*

Persons in family/household	225% of 2019 Federal Poverty Guidelines
1	$ 28,102.50
2	$ 38,047.50
3	$ 47,992.50

For households of more than three members please log onto our website at www.broward.org/bct to access the complete TD Income Guidelines chart.

Completed TD applications must contain all requested information. You are required to submit identification and applicable financial supporting documents when submitted. Self-declaration of income is not accepted. Faxed or Emailed applications are not accepted due to the collection of individually identifiable information**.**

Complete application information prior to printing and submitting.

Mail to: Paratransit Eligibility Services
Broward County Transit
1 N. University Dr., Suite 2400-B
Plantation, FL 33324
Information: 954-357-8400
(Mail or hand deliver application to the above address)

NOTICE OF COLLECTING SOCIAL SECURITY NUMBER (SSN) FOR GOVERNMENT PURPOSE
Broward County collects SSNs for different purposes. The Florida Public Records Law, Section 119.071(5), F.S. (2007) requires County to give you this written statement explaining the purpose and authority for collecting your SSN.

FORM	PURPOSE	AUTHORIZATION
TD Application	Conduct eligibility verification and monitor for system abuse	County policy (See Note)

NOTE: Broward County collects your SSN in the performance of a duty or responsibility County must complete in accordance with law or business necessity. In the event a law does not specifically provide County with the authority to collect your SSN, it is imperative County collect your SSN and this is expressly provided in section 119.081 (5) 2.b.

Transportation Disadvantaged Application
BUS PASS PROGRAM
Broward County Transit

Office Use Only
Client ID: _____
Date Approved: _____
Date Denied: _____

Instructions:
Complete Sections 1 and 2. Attach all required documentation. Self-declaration of income is not accepted.

A copy of your Current Florida Driver's License / Florida ID Showing a Broward County address is required.

SECTION 1 – GENERAL INFORMATION (PLEASE PRINT LEGIBLY)

Name of Applicant:	Phone:
Home Address:	
Mailing Address (if different):	
If using agency to receive mail, provide agency letter stating they will receive your mail	
Is a vehicle registered in your name? YES ☐ NO ☐ Do you drive? YES ☐ NO ☐	
Date of Birth:	Social Security Number:
Are you receiving Medicaid? YES ☐ NO ☐	If YES, Medicaid #:
Emergency Contact:	Phone:
Number of ***relatives***, including self, living in household: _____	Enter Total Annual Household Income Here (**lines 1 through 8 below**): _____

In order for us to determine your household income, please submit a copy of all current annual income/benefit(s) received by you and/or any relative(s) living in the residence.*

1. Most recent pay stub with year-to-date reporting $_____
2. DCF Benefits / Cash Assist. / Food Stamps with benefit amount $_____
3. Unemployment Compensation $_____
4. Social Security Awards Letter (SSA / SSI / SSDI) $_____
5. Retirement / Pension / Investment $_____
6. Disabled Veteran Benefits $_____
7. Housing benefits (HUD, Section 8) *(Not Happy Choice Voucher)* $_____
8. Other (Specify) $_____

Self Declarations are not accepted as proof or lack of income.

***If $0 income, and you live in a house or apartment, indicate how rent / utilities are paid (this includes balance remaining after rent subsidy).**

Additional documentation may be required to support household income.

(OVER)

SECTION 1 – GENERAL INFORMATION (CONTINUED) (PLEASE PRINT LEGIBLY)

VETERAN'S INFORMATION

Are you a United States veteran? YES ____ NO ____

If YES, type of Military Discharge:

Honorable ____ General (Honorable Conditions) ____

If YES, attach Proof of Honorable Discharge.
Need a copy of your Discharge?
Contact Broward County Elderly and Veterans Services by calling 954-357-6622.

SECTION 2 – HOUSEHOLD MEMBERS (RELATIVES)

NAME	DATE OF BIRTH	RELATIONSHIP	SOCIAL SECURITY NUMBER

Did you attach a copy of your FL ID or Drivers license? Yes _____ No _____
Did you attach all required documents? Yes _____ No _____

I attest all information is correct and if there are any changes, I will report them to TOPS! Paratransit Services immediately. **(DO NOT E-MAIL OR FAX)**

_____ _____
Signature of Applicant Date

_____ _____
Signature of Preparer (if other than applicant) Date

_____ _____
Print Name (Preparer) Relationship

Return to: Broward County Transit - Paratransit Services Eligibility
1 N University Dr., 2400 - B, Plantation, FL 33324
(Mail or hand deliver application to the above address)

Transportation Disadvantaged Application
DOOR-TO-DOOR PARATRANSIT SERVICES
Broward County Transit

Office Use Only
Client ID: _____
Date Approved: _____
Date Denied: _____

Instructions:
Complete Sections 1 and 2. Section 3 must be completed by a Florida Licensed Physician. Attach all required documentation. Self-declaration of income is not accepted.

A copy of your Current Florida Driver's License / Florida ID Showing a Broward County address is required.

SECTION 1 – GENERAL INFORMATION (PLEASE PRINT LEGIBLY)

Name of Applicant:	Phone:
Home Address:	
Mailing Address (if different):	
If using agency to receive mail, provide agency letter stating they will receive your mail	
Is a vehicle registered in your name? YES ☐ NO ☐ Do you drive? YES ☐ NO ☐	
Date of Birth:	Social Security Number:
Are you receiving Medicaid? YES ☐ NO ☐	If YES, Medicaid #:
Emergency Contact:	Phone:
Number of ***relatives***, including self, living in household: _____	Enter Total Annual Household Income Here (**lines 1 through 8 below**): _____

For us to determine your household income, please submit a copy of all current annual income/benefit(s) received by you and/or any relative(s) living in the residence.*

1. Most recent pay stub with year-to-date reporting $_____
2. DCF Benefits / Cash Assist. / Food Stamps with benefit amount $_____
3. Unemployment Compensation $_____
4. Social Security Awards Letter (SSA / SSI / SSDI) $_____
5. Retirement / Pension / Investment $_____
6. Disabled Veteran Benefits $_____
7. Housing benefits (HUD, Section 8) *(Not Happy Choice Voucher)* $_____
8. Other (Specify) $_____

Self Declarations are not accepted as proof of lack of income.

***If $0 income, and you live in a house or apartment, indicate how rent / utilities are paid (this includes balance remaining after rent subsidy).**

Additional documentation may be required to support household income.

(OVER)

SECTION 1 – GENERAL INFORMATION (CONTINUED) (PLEASE PRINT LEGIBLY)

VETERAN'S INFORMATION

Are you a United States veteran? YES ____ NO ____

If YES, type of Military Discharge:

Honorable ____ General (Honorable Conditions) ____

If YES, attach Proof of Honorable Discharge.

Need a copy of your Discharge?
Contact Broward County Elderly and Veterans Services by calling 954-357-6622.

SECTION 2 – HOUSEHOLD MEMBERS (RELATIVES)

NAME	DATE OF BIRTH	RELATIONSHIP	SOCIAL SECURITY NUMBER

Did you attach a copy of your FL ID or Drivers license? Yes _____ No _____
Did you attach all required documents? Yes _____ No _____
Is the Medical Form completed by a Florida Licensed Physician? Yes____ No ____

I attest all information is correct and if there are any changes, I will report them to TOPS! Paratransit Services immediately. **(DO NOT E-MAIL OR FAX)**

_____ _____
Signature of Applicant Date

_____ _____
Signature of Preparer (if other than applicant) Date

_____ _____
Print Name (Preparer) Relationship

Return to: Broward County Transit - Paratransit Services Eligibility
1 N University Dr., 2400 - B, Plantation, FL 33324
(Mail or hand deliver application to the above address)

Transportation Disadvantaged Application
Door-To-Door Paratransit Service
Broward County Transit
Section 3 – MEDICAL

Client ID: _____

Applicant Name: _____ Date of Birth: _____

SECTION 3 – MEDICAL (TO BE COMPLETED BY FLORDIA LICENSED PHYSICIAN)

Does applicant have Medicaid? Yes ____ No ____ If Yes, Medicaid #: _____

Medicaid Program Code: _____

Indicate Mobility Aides / Equipment / Disability Condition(s):

Mobility Aides / Equipment:

Crutches ___ Scooter ___ W/C ___ PWR W/C ___ Walker ___ Cane ___ Leg Brace ___

Back Brace ___ AMBI ___ None ___ O2 Tank ___ Other _____

Disability Condition(s):

Functional ___ Hearing ___ Visual ___ Cognitive ___

Please explain below how the applicant's disability stops the applicant from independently using the BCT fixed-route bus? *(BCT Buses are 100% handicapped accessible).*

_____

_____

_____

_____

I, the undersigned, certify the medical information provided on this 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.

_____ _____
Physician's Signature Florida Medical License Number

_____ _____
Physician's Name (Print Legibly) Contact Number

Broward County Transit		
April 24, 2019	**Paratransit**	Number # SOP-
Category: **SOP**		
Subject: **TD DOOR to DOOR ELIGIBILITY**		

PURPOSE:

To establish procedures to assess and administer TOPS Applications for the Transportation Disadvantaged Door to Door Service per the Florida Commission for the Transportation Disadvantaged (TD), and other funding grants as authorized and approved through Broward County Paratransit.

POLICY:

Eligibility for TOPS service, under Transportation Disadvantaged, is defined by the Transportation Disadvantaged Service Plan. TD paratransit customers re-apply every year. No self-declaration is allowed. To approve income verification, official documents are required.

PROGRAM PROCEDURE:

Shared-ride paratransit transportation is provided to eligible Broward County residents with physical, cognitive, emotional, visual, or other disabilities which functionally prevent them from using the BCT fixed-route bus system permanently, temporarily or under certain conditions. Door-to-door paratransit transportation is provided to health care, employment, education, shopping, social activities and other life-sustaining activities. The following criteria are used by the Eligibility Department for determining TD eligibility for Door-to Door Paratransit:

1. Applicant is a current resident of Broward County, FL.

2. No other funding is available to pay for the requested trip (i.e. Medicaid)

3. TD eligibility criteria requires the applicant to qualify under **both disability AND current Federal Poverty Level Guidelines**, depending on the number of family members in household, at the 225 percent level

Processing Procedure: Transportation Disadvantaged Paratransit Application

1. Door-to-Door Paratransit Service Application is reviewed by eligibility staff for the following:
    a. Required ID: - Copy of current/valid FL driver's license or FL ID card with Broward County address required.

b. Section 1: General Information on Door –to –Door Application
    i. Name of Applicant – Must be full/legal name (same as ID)
    ii. Phone – Required
    iii. Home Address – Address where living
    iv. Mailing Address – If shelter, current letter indicating receipt of client mail approved
    v. Is a Vehicle Register in your name – Verify completed
    vi. Do you drive – verify completed
    vii. DOB – must be completed and same as ID
    viii. SSN – Must be completed
    ix. Are you receiving Medicaid – Must be completed (If yes, must have number)
    x. Emergency Contact Name/Phone – Must be completed
    xi. Relatives Living in Household – Must be completed (verify with supporting financial documents if applicable)
    xii. Total Annual Household Income – Must be completed
c. Section 1: Annual income/benefits of ALL family members in household (#s 1-8) verify completed information with most current documentation. Provide the following financial information:
    i. Most recent pay stub with year-to-date reporting
    ii. DCF Benefits / Cash Assist. / Food Stamps with benefit amount
    iii. Unemployment Compensation
    iv. Social Security Awards Letter (SSA / SSI / SSDI)
    v. Retirement / Pension / Investment
    vi. Disabled Veteran Benefits
    vii. Housing benefits (HUD, Section 8) *(Not Happy Choice Voucher*)
    viii. Other (Specify)
d. Paratransit staff verifies total household income within current FPL guidelines
e. If $0 income & living in house/apt. how paying rent/utilities to be verified
    i. Verify online with Property Appraiser for owner
f. Veteran's Information – Must be completed (if Yes, copy of discharge attached)
g. Section 2 Household Members
    i. If 1 in household, this section is blank
    ii. If more than 2 in household, equal number of relative must be listed and financial documentation included in Section 1
h. Bottom of Section 2:
    i. Attestation
    ii. Must be signed and dated by applicant (& preparer if applicable)
i. Section 3 – Medical (must be completed by licensed FL physician)

    Reason/Condition applicant disability prevents use of fixed route bus –

    Indication of mobility aides/equipment/disability conditions

i.1 Explanation – must be completed

i.2 Attestation (all information must be completed)

i.3 Must be signed and dated by FL physician

2. Applicant information is entered into ADEPT database.

3. If determined eligible for Door to Door Paratransit Service, all relevant ADEPT screens are completed.

4. Based on evaluation of application, applicant is notified via mail of decision and sent one of the following letters:
    a. Approved for TD General
    b. Approved for TD Conditional (ADEPT codes NM/MO/XT)

        MO: To/From Medical/Health Care Facilities

        NM: No Medical Trips. Applicant currently has a Medicaid program which supplies medical trips to free of charge. Applicant must travel with a Medicaid transportation provider as a Medicaid client for all medical trips.

        XT: TD Program guidelines require using the closest available facilities for all trips with the following exception: Trips for Dialysis sites must be within 5 miles from residence; Trips for Chemo/Radiation sites must be within 10 miles from residence.

    c. Denied TD paratransit

3. Application determination letters are sent daily to notify clients of the eligibility decision based on the submitted application.

    a. Collect all applications from the wooden boxes on the file cabinets. Keep applications separated, “Eligible” or “Not Eligible – Return”. Alphabetize applications within each group.
    b. Open “G” drive – Select ACCESS DP PROCS- DATABASE- ELIG LTRS- PRINT ELIG LTRS.
    c. Select PRINT
    d. Match printed letter with application source document:
        i. Not Eligible - RETURN – Match with copy of return document and mail
        ii. ELIGIBLE – Letter, Bus Pass number, 31-day bus pass, and a “Bus Pass Request” postcard is folded and mail.
        iii. NON-Eligible – Fold letter (include appeal letter if appropriate)
            i. Source application document and appeal letter to Eligibility Specialist for scanning.
            ii. Denial and appeal letter folded and mailed.
4. All documents received (applications, financial, medical forms, etc.) are scanned unless they are duplicates. If they are duplicates, they are shredded.
5. Processed documents are placed in the scan box.
6. All documents in the scan box are scanned and saved in the G:drive:

a. Select: TDPROGRAM
b. Select TD Scanned Applications
c. Select year application processed
d. Save document by client last name

After document is scanned, place it in a cardboard box to be shredded by a local company once a year.

Broward County Transit		
April 24, 2019	**Paratransit**	Number # SOP-
Category: **SOP**		
Subject: **TD BUS PASS ELIGIBILITY Process**		

PURPOSE:

To establish procedures to assess and administer TOPS Applications for the Transportation Disadvantaged Bus Pass Program per the Florida Commission for the Transportation Disadvantaged (TD), and other funding grants as authorized and approved through Broward County Paratransit.

POLICY:

Eligibility for the income-based Transportation Disadvantaged 31-Day free Bus Pass Program is defined by the Transportation Disadvantaged Service Plan. Eligibility for the Bus Pass Program is solely income based. TD Bus Pass customers must re-apply every year.

PROGRAM DESCRIPTION:

1. The required Transportation Disadvantaged Bus Program application can be obtained through the following methods :
    a. Call Customer Service at 954-357-8400 and it will be mailed to the caller
    b. The application can be downloaded from the Paratransit website http://www.broward.org/BCT/Pages/Paratransit.aspx
    c. Application can be picked up at Broward County Transit,
        1 N. University Drive, Plantation, FL 33324

2. The following criteria are used by the Eligibility Department for determining TD eligibility for the Transportation Disadvantaged Bus Pass Program:
    a. Applicant is a current resident of Broward County, FL.
    b. The following income criteria is met: Household income is equal to or less than 225% of the Department of Health and Human Services Federal Poverty Guidelines which is printed annually in the Federal Register.

Application Processing Procedure

1. The Transportation Disadvantaged Bus Pass Program application is reviewed by eligibility staff for the following:
    a. Required ID: Copy of current/valid FL driver's license or FL ID card with Broward County address required.

Section 1: General Information:

b. Name of Applicant – Must be full/legal name (same as ID)
c. Phone – Required
d. Home Address – Address where living
e. Mailing Address – If shelter, current letter indicating receipt of client mail approved
f. Is a Vehicle Register in your name – Verify completed
g. Do you drive – Verify completed
h. DOB – Must be completed and same as ID
i. SSN – Must be completed
j. Are you receiving Medicaid – Must be completed (If yes, must have number)
k. Emergency Contact Name/Phone – Must be completed
l. Number of Relatives Living in Household – Must be completed (verify with supporting financial documents if applicable)
m. Total Annual Household Income – Must be completed.

2. Annual income/benefits of ALL family members in household (#s 1-8). Verify completed information with most current income documentation. No self-declaration allowed. To approve income verification the following official documents are required:
    a. Most recent pay stub with year-to-date reporting
    b. DCF Benefits / Cash Assist. / Food Stamps with benefit amount
    c. Unemployment Compensation
    d. Social Security Awards Letter (SSA / SSI / SSDI)
    e. Retirement / Pension / Investment
    f. Disabled Veteran Benefits
    g. Housing benefits (HUD, Section 8) *(Not Happy Choice Voucher*)
    h. Other (Specify)

3. Verify total household income within current Federal Poverty Level guideline.

4. If $0 income & living in house/apt. how paying rent/utilities to be verified
    a. Verify online with Property Appraiser for owner

5. No self-declaration allowed. To approve income verification official documents are required.

6. Veteran's Information – Must be completed (if Yes, copy of discharge attached)

Veterans Information

a. Are you a United States veteran/ Yes OR No
b. If YES, type of Discharge: Honorable Or General
c. If YES, attach a copy of Discharge
d. Need a copy of your Discharge? Contact Broward County Elderly and Veterans Services 954-357-6622.

7. Section 2 Household Members
   a. If 1 in household, this section is blank
   b. If more than 2 in household, equal number of relative must be listed and financial documentation included in Section 1
   c. If more than 2 in household, provide: Name, Date of Birth, Relationship and Social Security Number.

Bottom of Section 2:

   d. Attestation
   e. Must be signed and dated by applicant (& preparer is applicable)

8. Applicant household income must not exceed 225% of the Department of Health and Human Services Federal Poverty Guidelines which is printed annually in the Federal Register.

9. Applicant information is entered into ADEPT database.

10. If determined eligible for the Bus Pass Program, all relevant ADEPT screens are completed.

11. Applicant is notified via mail of decision and sent one of the following letters:
    a. Eligibility approved letter with Client ID, date eligibility expires, Bus Pass number, 31-day bus pass and a “Bus Pass Request” postcard.
    b. Return Letter detailing the required information to complete the application.
    c. Non-Eligible Letter- explaining why the applicant is not eligible for the program.

12. Application determination letters are sent daily to notify clients of the eligibility decision based on the submitted application.
    a. Collect all applications from the wooden boxes on the file cabinets. Keep applications separated, “Eligible” or “Not Eligible – Return”. Alphabetize applications within each group.
    b. Open “G” drive – Select ACCESS DP PROCS- DATABASE- ADEPT ELIG LTRS- PRINT ELIG LTRS.
    c. Select PRINT
    d. Match printed letter with application source document:

        i. Not Eligible - RETURN – Match with copy of return document and mail
        ii. ELIGIBLE – Letter, Bus Pass number, 31-day bus pass, and a “Bus Pass Request” postcard is folded and mail.
        iii. NON-Eligible – Fold letter (include appeal letter if appropriate)
        iv. DENIAL and APPEAL letters - Fold and mail.

13. Distribute application document and appeal letter to Eligibility Specialist for scanning.

14. All documents received (applications, financial, medical forms, etc.) are scanned unless they are duplicates. If they are duplicates, duplicate documents are shredded.
15. Processed documents are placed in the scan box.
16. All documents in the scan box are scanned and saved in the G:drive:
    a. Select: TDPROGRAM
    b. Select TD Scanned Applications
    c. Select year application processed
    d. Save document by client last name, first name, client ID, type of document (if applicable)
17. After document is scanned, place it in a cardboard box to be shredded by a local company once a year.