MID FLORIDA
COMMUNITY SERVICES, INC.

Helping People. Changing Lives.
community Action
PARTNERSHIP
AMERICA'S POVERTY FIGHTING NETWORK

TRANS HERNANDO

The State of Florida Commission for the Transportation Disadvantaged mandates that an application must be on file for **every** rider, even if the individual resides in a nursing home. Since the Commission operates through state government funding, anyone who has a trip **must** have a written and signed application on file, either by Client or Guardian, indicating that they meet the definition of "Transportation Disadvantaged".

Regardless of request for reduction in fare, **all** individuals requesting transportation must have their eligibility **recertified on a yearly basis**. Please complete the enclosed application and return to the address listed on the application form as soon as possible and **prior to scheduling your next trip**.

Reduced fare box fee is available and based on federal poverty guidelines. If you would like to be considered for reduced fare box fee, you must provide proof of income in addition to completing the Income Source information section. Applications received without proof of income will not be considered for reduced fare box fee, and the fare box fee will be $5.00 each way, $10.00 round trip.

Should you have need of further information, please contact our office at the phone number listed above. Thank you in advance for your prompt attention to this matter.

TRANS HERNANDO

APPLICATION FOR TRANSPORTATION DISADVANTAGED SERVICES

This application form must be completed to receive transportation services through the State Transportation Disadvantaged funding. Fare box fee is $5.00 each way, $10.00 round trip. Reduced fare box fee is available and based on federal poverty guidelines. Reduced fare box fee will ONLY be considered when the Income Source information is completed and proof of this income provide for all members of the household. Information contained in this application is private, confidential, and protected under the "Right to Privacy Act" and "HIPAA" and will not be shared.

If you reside within ¾ miles of the Hernando County Fixed Route (TheBus), you may not eligible for the Transportation Disadvantaged program. Please contact 352-754-4444 for more information.

Please refer to the enclosed brochure for additional information regarding the Transportation Disadvantaged system. If you need further information or assistance in completing this application, please contact 352-799-1510.

Name of Primary Applicant :_____
(List Additional household members on 2nd page)

Date of Birth:_____ Home Phone #:_____ Cell Phone #:_____

Address: _____City:_____ State: _____ Zip:_____

Social Security # (Required):_____Medicaid #:_____

Do you own a vehicle?_____If yes, do you sometimes drive?_____

Are you? ____Over the age of 55 ____Child (under 17) escort required

____Over the age of 55 and disabled – Limitations _____

____ Disabled - Limitations_____

_____ A veteran If so, must provide proof of service (i.e. DD214 form, etc.).

Will this transportation be used for employment? If so, you must provide proof of employment (i.e. pay stub). Yes_____ No _____

Do you require an escort (over 17) to accompany you? Yes_____ No_____
(If yes, it is the passenger's responsibility to advise the office that an escort is needed prior to scheduling a trip)

Do you use Mobility Assistance? (All wheelchairs must have working brakes and the footrests attached)

_____Regular Wheelchair (No transport chairs allowed) _____Walker _____Cane

_____Motorized Wheelchair/Scooter (All motorized wheelchairs/scooters must be inspected and approved by management prior to scheduling.)

If you are using oxygen, tank must be portable and able to be carried by client and/or attached to wheelchair.
Oxygen tank on wheeled carrier is not permitted.

I attest that all information provided on this application is correct and that any changes will be reported to Trans Hernando as they occur.

Signature of Applicant: _____Date:_____

Please return application to:

TRANS HERNANDO
Attn: Finance
1122 Ponce De Leon Blvd.
Brooksville, FL 34601
OR FAX 352-754-9390

MID FLORIDA COMMUNITY SERVICES, INC.
Helping People. Changing Lives.
community Action PARTNERSHIP
AMERICA'S POVERTY FIGHTING NETWORK

Total number living in household: _____ (list each name, date of birth and social security number

Income received monthly

To be considered for the reduced fare box fee, the entire household income must be taken into consideration. Reduced fare box fee is based on federal poverty guidelines. Indicate the amount of income received by each household member for the following sources: Proof of income must be attached to be considered for a fare reduction (based on the Federal Poverty Guidelines).		Additional Household Member #1	Additional Household Member #2	Additional Household Member #3
		Name:	Name:	Name:
		Birth Date:	Birth Date:	Birth Date:
	Self	Social Security #:	Social Security #:	Social Security #:
INCOME SOURCE				
Current Employment				
Social Security/SSI Benefits				
Retirement Income (Pension)				
Investment Income				
Food Stamps				
Child Support				
OTHER/MISC				
Total Monthly Income	$	$	$	$