Transportation Disadvantaged (TD)
Application Review Working Group Meeting
September 29, 2020; 1:00 p.m.

PUBLIC ACCESS:	To join the meeting from your computer, tablet or smartphone, and for dial-in instructions, please use this link: https://metroplanorlando.org/meetings/td-application-review-working-group-08-19-20/2020-09-29/
PANELIST ACCESS:	To join the meeting from your computer, tablet or smartphone, please use the personalized invitation sent to you via email from "MetroPlan Orlando." Reminders will be sent up to one hour prior to the meeting. When connecting be sure that your name is accurately displayed.

This meeting is being hosted by MetroPlan Orlando using the Zoom webinar platform. Our offices are closed to the public in response to the COVID-19 pandemic, however members of the public may access this virtual meeting and participate via the Zoom link above, or by dialing in. The agenda is available at MetroPlanOrlando.org in the Calendar section. New to Zoom? You can get the app ahead of time and be ready for the meeting. Visit Zoom.us.

AGENDA

1. Welcome
2. Call to Order – Mr. Wayne Olson, Working Group Chair
3. Statement of Purpose and Criteria
4. Review and discussion – Medical Forms Tab 1
5. Review and discussion – Percent Poverty Level Tab 2
6. Next Meeting Topic
7. Public Comments
8. Adjournment

Public participation is conducted without regard to race, color, national origin, sex, age, disability, religion, or family status. Persons wishing to express concerns, who require special assistance under the Americans with Disabilities Act, or who require language services (free of charge) should contact MetroPlan Orlando by phone at (407) 481-5672 or by email at info@metroplanorlando.org at least three business days prior to the event.

La participación pública se lleva a cabo sin distinción de raza, color, origen nacional, sexo, edad, discapacidad, religión o estado familiar. Las personas que deseen expresar inquietudes, que requieran asistencia especial bajo la Ley de Americanos con Discapacidad (ADA) o que requieran servicios de traducción (sin cargo) deben ponerse en contacto con MetroPlan Orlando por teléfono (407) 481-5672 (marcar 0) o por correo electrónico info@metroplanorlando.org por lo menos tres días antes del evento.

TAB 1

PHYSICIAN CONTACT

To allow the JTA Connexion staff to make a fair assessment of your application, we may need to contact a medical professional who is familiar with your condition(s). Please complete the information below:

- Name of Medical Professional: _____
- Medical Facility: _____
- Address:_____
- City: _____ Zip: _____ County: _____ Phone: _____

Title of Medical Professional:

☐ Physician	☐ Optometrist	☐ Licensed Mobility Specialist
☐ Physician's Assistant	☐ Rehabilitation Specialist	☐ ESE Teacher
☐ RN or LPN	☐ Occupational Therapist	☐ Social Worker
☐ Psychologist	☐ Physical Therapist	

APPLICANT SIGNATURE

I acknowledge the purpose of this application is to determine my ability to use transit and paratransit services. I understand that the staff of the Jacksonville Transportation Authority (JTA) and JTA Connexion may need to discuss my application to obtain additional information. I have been truthful in answering all of these questions and my information may be verified. I authorize the health care professional, including psychiatrists or psychologists, designated in this application to release and provide JTA and JTA Connexion, or its representatives, any additional information that may be required to complete or clarify this application. I agree that, when possible, I will travel to the nearest location that can serve my needs and understand that this will allow JTA to most efficiently serve the needs of the community.

I certify that, to the best of my knowledge, the information given is correct.

Please note that any person who knowingly makes a false or misleading statement in an application or certification under section 320.0848, Florida Statutes, commits a misdemeanor of the first degree, punishable as provided in section 775.082 or 775.083, F.S. The penalty is up to one year in jail or a fine of $1,000.

Applicant Signature:_____ Date:_____

If applicant signed their name above, but you helped this person to answer these questions, please sign and print your name below:

Signature: _____

Printed Name: _____

Relationship to Applicant: _____

Phone Number: _____

LARGE PRINT, BRAILLE AND ALTERNATIVE FORMATS AVAILABLE UPON REQUEST AFTER THE APPLICATION IS COMPLETED CALL 265-6001 TO SCHEDULE AN INTERVIEW.

Signature of Medical Professional _____ Date_____

Professional License # _____ State Issued _____

Print Name_____
Address_____
City _____ State_____ Zip Code _____
Phone # _____ Extension _____
Contact person _____

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_____

Applicant Signature Date

If applicant is unable to sign this form, he/she may have someone sign on his/her behalf.

_____

Signing for Applicant Relationship Date

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

MEDICAL VERIFICATION

(THIS PORTION TO BE COMPLETED BY APPLICANT)

Please Print/Type Below

I certify that I am a person with a disability as described by the American with Disabilities Act. I further state that my physician or other certifying practitioner has completed the statement of certification below on my behalf, as required.

Name of Applicant as printed on the Identification

Signature of Applicant, Parent or Guardian of Applicant

Date of Birth Sex

Date Signed

Street Address City State Zip Code

MEDICAL VERIFICATION, CONTINUED

(THIS PORTION TO BE COMPLETED BY A LICENSED PHYSICIAN)

1. Keeping in mind that all Palm Tran buses are 100% wheelchair accessible, can the applicant ever use a regular bus?

☐ **Yes** ☐ **No** ☐ **Sometimes**

2. **MOBILITY IMPAIRMENT:**

☐ Non-ambulatory disability (required wheelchair to travel) Please specify the condition which requires full time use of a wheelchair. _____

☐ Ambulatory disability (ambulation may be limited, but able to walk with or without mobility aid, may use wheelchair but can transfer to a seat with little or no assistance).

☐ Amputation (detail extremity): _____

☐ Stroke

☐ Brain Spinal Nerve Trauma

☐ Other: _____

3. **MOBILITY AID: PLEASE INDICATE ALL THAT APPLY**

☐ Standard Wheelchair ☐ Cane ☐ Other: _____

☐ Wide Wheelchair ☐ Walker

☐ Scooter ☐ Crutches _____

☐ Wide Scooter ☐ Braces

☐ Service Animal

4. **NEUROLOGICAL DISABILITY (MOTOR DYSFUNCTION):**

☐ Multiple Sclerosis ☐ Epilepsy ☐ Other: _____

☐ Muscular Dystrophy ☐ Alzheimer's

☐ Cerebral Palsy ☐ Parkinson's _____

5. **VISUAL DISABILITY:**

☐ Macular Degeneration

☐ Visually Impaired

☐ Legally Blind – If this person is legally blind complete the following:

Corrected visual acuity: Right Eye _____ Left Eye _____ *(Please attach Snellen reports of both eyes)*

Corrected Field of vision: Right Eye _____ Left Eye _____ *(Please attach Perimeter chart reports of both eyes)*

6. **UNCONTROLLED FATIGUE:**

☐ Chemo/Radiation ☐ Dialysis

MEDICAL VERIFICATION, CONTINUED

(TO BE COMPLETED BY A LICENSED PHYSICIAN)

7. COGNITIVE OR SENSORY IMPAIRMENT:

☐ Autism ☐ Dementia ☐ Other:_____
☐ Down Syndrome ☐ Alzheimer's
☐ Developmental Disability ☐ Emotional _____

Level of impairment: ☐ Mild ☐ Moderate ☐ Severe ☐ Profound I.Q.: _____ (*Must specify*)

8. IMPAIRMENT RELATED CONDITION:

☐ Hearing Impaired ☐ Arthritis ☐ Other:_____
☐ Cardiac ☐ Neuropathy
☐ Respiratory / COPD _____

9. DESCRIBE IN DETAIL THE APPLICANT'S PRIMARY DISABILITY: (BE SPECIFIC):

_____

_____

10. IS THIS DISABILITY:

☐ Permanent
☐ Temporary: This is to certify that the applicant stated within is a person with a temporary disability (six months or less) that limits or impairs his/her ability to walk or is temporarily sight impaired.
Date of Disability: _____ ***through recovery date of*** _____

Is this disability controlled by medication? ☐ Yes ☐ No
Explain:_____

_____

_____

Please attach any pertinent medical documentation (Test Results, Notes, Reports, etc.) that would help to explain the diagnosis or limitations on the applicant's ability to utilize Palm Tran's mass transit system.

WARNING: ***Any person who knowingly makes a false or misleading statement in an application or certification may be denied eligibility to Paratransit services.***

Print/Type Name of Certifying Medical Authority	Signature	Date Signed
Business Street Address	(Area Code) Telephone Number	Fax Number
City	State	Zip Code

Certification or License No. (REQUIRED)_____

LICENSED IN THE STATE OF:_____

Applicant Name, Nombre del Solicitante

Medical Verification – To be completed by a licensed professional.

Please complete the section below. The information that you provide must be based solely upon the applicant having an actual physical or cognitive limitation, which prevents the use of our fixed route bus service. The diagnosis of a potentially limiting illness or condition is not sufficient determination for paratransit services.

What is the applicant's disability? _____

_____

_____

How does the condition functionally prevent the applicant from using regular bus service?

_____

_____

_____

If temporary, what is the duration? _____

Signature of Medical Professional _____ Date _____

Professional License # _____ State Issued _____

Print Name _____

Address _____

City _____ State _____ Zip Code _____

Phone # _____ Extension _____

Contact person _____

Applicants Release:

I understand that the purpose of this evaluation form is to determine my eligibility for paratransit service. I understand that the information about my disability contained in this application will be kept confidential and shared only with professionals involved in evaluating my eligibility. I hereby authorize my medical representative to release any and all information regarding my medical condition to LYNX. I understand that providing false or misleading information could result in my eligibility status being revoked. I agree to notify ACCESS LYNX within 10 days if there is any change in circumstances or I no longer need to use paratransit services.

Permiso del Solicitante:

Yo al firmar el espacio correspondiente, entiendo que esta solicitud es para determinar la elegibilidad para los servicios de paratransit, transporte puerta a puerta, atravez de ACCESS LYNX. Entiendo que la información dada por mi acerca de mi incapacidad será mantenida de manera confidencial, y será compartida solamente con los profesionales relacionados con la evaluación, y determinación de elegibilidad para los servicios que estoy solicitando. A la vez, autorizo a mi representate médico que provea a LYNX toda información correspondiente a mi condición médica. Entiendo, que el proveer información falsa o erronea a LYNX, podria resultar en que mi elegibilidad para los servicios que solicito no pueda llegar a determinarse, incluso una vez determinada, pueda ser revocada. Yo, en acuerdo, notificaré a ACCESS LYNX dentro de 10 días si ha surgido algun cambio en circunstancias, o si no he de necesitar los servicios de paratransito.

_____

Applicant Signature, Firma del Solicitante Date, Fecha

If applicant is unable to sign this form, he/she may have someone sign on his/her behalf.
Si el solicitante no puede firmar la solicitud, el o ella puede designar a otra persona que firme por el solicitante.

_____

Signing for Applicant, Firmando por Solicitante Relationship, Relación Date, Fecha

TAB 2

Research on Poverty Level Eligibility

SNAP

If all members of your household are receiving Temporary Assistance for Needy Families (TANF), SSI, or in some places other general assistance, your household may be deemed “categorically eligible” for SNAP because you have already been determined eligible for another means-tested program.

The information provided in the table below applies to households in the 48 contiguous states and the District of Columbia that apply for SNAP between October 1, 2019, through September 30, 2020.

Table 1: SNAP Income Eligibility Limits - **October 1, 2019, through September 30, 2020**

Household Size	Gross monthly income (130 percent of poverty)	Net monthly income (100 percent of poverty; test for SNAP households with elderly and disabled members)
1	$1,354	$ 1,041
2	$1,832	$1,410
3	$2,311	$1,778
4	$2,790	$2,146
5	$3,269	$2,515
6	$3,748	$2,883
7	$4,227	$3,251
8	$4,705	$3,620
Each additional member	+$479	+$369

* SNAP gross and net income limits are higher in Alaska and Hawaii.

What deductions are allowed in SNAP?

The following deductions are allowed for SNAP:

- A 20-percent deduction from earned income.
- A standard deduction of $167 for household sizes of 1 to 3 people and $178 for a household size of 4 (higher for some larger households and for households in Alaska, Hawaii, and Guam).
- A dependent care deduction when needed for work, training, or education.

- Medical expenses for elderly or disabled members that are more than $35 for the month if they are not paid by insurance or someone else. The excess medical expenses deduction is described below.
- In some states, legally owed child support payments.
- In some states, a standard shelter deduction for homeless households of $152.06.
- Excess shelter costs as described below.

SNAP Excess Medical Expenses Deduction

For elderly members and disabled members, allowable medical costs that are more than $35 a month may be deducted unless an insurance company or someone who is not a household member pays for them. Only the amount over $35 each month may be deducted.

Allowable costs include:

- most medical and dental expenses, such as doctor bills, prescription drugs and other over-the-counter medication when approved by a doctor;
- dentures, inpatient and outpatient hospital expenses; and
- nursing care.

They also include other medically related expenses such as:

- certain transportation costs;
- attendant care; and
- health insurance premiums.

The costs of special diets are not allowable medical costs.

Note: Proof of medical expenses and insurance payments is required.

SNAP Excess Shelter Costs Deduction

The shelter deduction is for shelter costs that are more than half of the household's income after other deductions.

Allowable shelter costs include:

- Fuel to heat and cook with.
- Electricity.
- Water.
- The basic fee for one telephone.
- Rent or mortgage payments and interest.
- Taxes on the home.

Some states allow a set amount for utility costs instead of actual costs.

The amount of the shelter deduction is capped at (or limited to) $569 unless one person in the household is elderly or disabled. The limit is higher in Alaska, Hawaii, and Guam. For a household with an elderly or disabled member all shelter costs over half of the household's income may be deducted.

Table 2: How to Calculate SNAP Net Income for Elderly/Disabled Household

Elderly/Disabled Household Income Computation	Example
Determine household size...	2 people who are elderly or disabled.
Add gross monthly income...	$1,000 Social Security + $200 pension = $1,200 gross income.
Subtract 20% earned income deduction...	$0 earned income
Subtract standard deduction...	$1,200 - $167 standard deduction for a 2-person household = $1,033
Subtract dependent care deduction...	0
Subtract child support deduction...	0
Subtract medical costs over $35 for elderly and disabled...	$1,033 - $300 excess medical expenses = $733
Excess shelter deduction...	
Determine half of adjusted income...	$733 adjusted income/2 = $366.50
Determine if shelter costs are more than half of adjusted income...	$600 total shelter - $366.50 (half of income) = $232.50 excess shelter cost
Subtract excess amount, but not more than the limit, from adjusted income...	$733 - $232.50 = $499.50 net monthly income
Apply the net income test...	Since the net monthly income is less than $1,410 allowed for 2-person household, the household has met the income test.

SSI

There are two slightly different versions of the federal poverty measure:

- The poverty thresholds, and
- The poverty guidelines.

The **poverty thresholds** are the original version of the federal poverty measure. They are updated each year by the **Census Bureau**. The thresholds are used mainly for **statistical** purpose — for instance, preparing estimates of the number of Americans in poverty each year. (In other words, all official poverty population figures are calculated using the poverty thresholds, not the guidelines.) Poverty thresholds since 1973 (and for selected earlier years) and weighted average poverty thresholds since 1959 are available on the Census Bureau's Web site. For an example of how the Census Bureau applies the thresholds to a family's income to determine its poverty status, see "How the Census Bureau Measures Poverty" on the Census Bureau's web site.

The **poverty guidelines** are the other version of the federal poverty measure. They are issued each year in the *Federal Register* by the **Department of Health and Human Services** (HHS). The guidelines are a simplification of the poverty thresholds for use for **administrative** purposes — for instance, determining financial eligibility for certain federal programs.

The poverty guidelines are sometimes loosely referred to as the "federal poverty level" (FPL), but that phrase is ambiguous and should be avoided, especially in situations (e.g., legislative or administrative) where precision is important.

The following figures are the 2020 HHS poverty guidelines which will be published in the Federal Register

2020 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

Search:

Persons in family/household	Poverty guideline
For families/households with more than 8 persons, add $4,480 for each additional person.	
1	$12,760

Persons in family/household	Poverty guideline
2	$17,240
3	$21,720
4	$26,200
5	$30,680
6	$35,160
7	$39,640
8	$44,120
8	$55,150

The separate poverty guidelines for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966-1970 period. Note that the poverty thresholds — the original version of the poverty measure — have never had separate figures for Alaska and Hawaii. The poverty guidelines are not defined for Puerto Rico, the U.S. Virgin Islands, American Samoa, Guam, the Republic of the Marshall Islands, the Federated States of Micronesia, the Commonwealth of the Northern Mariana Islands, and Palau. In cases in which a Federal program using the poverty guidelines serves any of those jurisdictions, the Federal office which administers the program is responsible for deciding whether to use the contiguous-states-and-D.C. guidelines for those jurisdictions or to follow some other procedure.

The poverty guidelines apply to both aged and non-aged units. The guidelines have never had an aged/non-aged distinction; only the Census Bureau (statistical) poverty thresholds have separate figures for aged and non-aged one-person and two-person units.

Programs using the guidelines (or percentage multiples of the guidelines — for instance, 125 percent or 185 percent of the guidelines) in determining eligibility include Head Start, the Supplemental Nutition Assistance Program (SNAP), the National School Lunch Program, the Low-Income Home Energy Assistance Program, and the Children's Health Insurance Program. Note that in general, cash public assistance programs (Temporary Assistance for Needy Families and Supplemental Security Income) do NOT use the poverty guidelines in determining eligibility. The Earned Income Tax Credit program also does NOT use the poverty guidelines to determine eligibility. For a more detailed list of programs that do and don't use the guidelines, see the Frequently Asked Questions(FAQs).

The poverty guidelines (unlike the poverty thresholds) are designated by the year in which they are issued. For instance, the guidelines issued in January 2020 are designated the 2020 poverty guidelines. However, the 2020 HHS poverty guidelines only reflect price changes through calendar year 2019; accordingly, they are approximately equal to the Census Bureau poverty thresholds for calendar year 2019. (The 2019 thresholds are expected to be issued in final form in September 2020; a preliminary version of the 2019 thresholds is now available from the Census Bureau.)

The poverty guidelines may be formally referenced as “the poverty guidelines updated periodically in the *Federal Registe*r by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2).”

Section 8 - Affordable Housing:

Section 8 Income Limits in Florida

Section 8 eligibility is largely based on household income. Every year the Department of Housing and Urban Development (HUD) establishes income limits based on county, median income and family size. Income limit is broken into three categories:

1. Low Income (80% of median income)
2. Very Low Income (50% of the median income)
3. Extremely Low Income (60% of the very low income level/30% of the median income)

In most cases, a family's household income must fall into the very low or extremely low categories to be eligible for Section 8 assistance.

FY 2017 Income Limits Summary

FY 2017 Income Limit Area	Median Income Explanation	FY 2017 Income Limit Category	Persons in Family 1	2	3	4	5	6	7	8
Orange County	$58,400	Very Low (50%) Income Limits ($) Explanation	20,450	23,400	26,300	**29,200**	31,550	33,900	36,250	38,550
		Extremely Low Income Limits ($)* Explanation	12,250	16,240	20,420	**24,600**	28,780	32,960	36,250*	38,550*
		Low (80%) Income Limits ($) Explanation	32,700	37,400	42,050	**46,700**	50,450	54,200	57,950	61,650