



## Transportation Disadvantaged (TD) Application Review Working Group Meeting

August 25, 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-08-19-20/2020-08-25/>

**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. Taskforce Chair – Nomination/Vote
3. Timeline of meetings
4. Purpose and Outcomes Tab 1
  - a. QATF Recommendations PDF (attached)
5. Criteria review with a focus on implementation and next year's TDSP Update Tab 2
  - a. Copy of TDSP Criteria (excerpt attached)
6. Prepare for Sept 1st Meeting Topic: "Peer" Review Tab 3
  - a. List of Peer Organizations researched
  - b. Any other agencies to review - taskforce
7. Prepare for Sept 8th Meeting Topic: Current Application Review Tab 4
  - a. Copy of Application (attached)
8. Public Comments

## 9. 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](mailto: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](mailto:info@metroplanorlando.org) por lo menos tres días antes del evento.

**TAB 1**

---

# Eligibility Criteria

QATF Recommendations



CTC Request	QATF Recommendation
<p>Separate the application process for each program (ADA and TD).</p> <p><b>Discussion point:</b> Update the TDSP list to only include approved criteria</p>	<p>✓ Recommend approval with review and approval of applications by QATF and LCB.</p>
<p><b>Discussion point:</b> Some customers have a specific number of medical insurance trips available to them as another means of transportation</p>	<p>✓ Availability of trips by another sponsoring agency should be disclosed on eligibility application.</p>

CTC Request	QATF Recommendation
<p><b><u>Current Criteria enforced:</u></b> If there is no fixed route available within the ¾ mile boundary of the customer’s home, the customer qualifies for TD services. The customer is not required to complete the medical form of the application and not required to complete the functional assessment.</p>	<p>! QATF members expressed concern with occupational therapists conducting functional assessment and essentially overriding doctors opinion. Also concerned with people who have cognitive disabilities. Mental health professionals needed.</p>
<p><b>Discussion point:</b> If the disability criteria becomes effective, the customer would have to be evaluated with a functional assessment for the TD service (both outside and inside the ¾ mile like the ADA customers).</p>	

CTC Request	QATF Recommendation
<p><b><u>Discussion point:</u></b> ACCESS LYNX does not have a procedure in place for determining the poverty level of an individual. A procedure would have to be developed and proper documents would be requested/required from the customer.</p>	<p>✓ QATF recommends removing individual and household income criteria and revisit if/when a procedure is established. Recommends such procedure be established in cooperation with the QATF and approved by LCB.</p>

### **Additional Recommendations:**

- Recommend requiring persons with permanent disabilities to verify/update contact information versus complete eligibility process as often could be a cost savings.
- Recommend call hold time performance measure not be increased to greater than 7 minutes.
- Recommend formation of Task Force to review application and eligibility criteria.

## **ACTIONS REQUESTED**

- 1. Motion to approve QATF's recommendations related to Eligibility Criteria**
- 2. Motion to approve minor updates to the Transportation Disadvantaged Services Plan, including revisions to the Eligibility Criteria section**



**TAB 2**

---



### **Transportation Disadvantaged (TD) Program Criteria**

For customers to access the TD program, they must first be certified as eligible. The eligibility process evaluates five areas for determination as developed by ACCESS LYNX and approved by the Local Coordinating Board (LCB). All eligible clients will be recertified every two (2) years to ensure that ACCESS LYNX has the most recent information for each customer.

#### **1. AVAILABILITY OF ANOTHER SPONSOR.**

The TD program will be the sponsor of last resort. No other funding available.

66

#### **2. NO OTHER MEANS OF TRANSPORTATION IS AVAILABLE.**

Applicant does not own his/her own vehicle or have access to one in his/her household. Applicant does not have friends or relatives who can take him/her places.

#### **3. \*AVAILABILITY OF FIXED-ROUTE SERVICE.**

All customers who are within three-quarters of a mile of LYNX fixed-route service will be required to use that service. For applicants outside the three-quarter mile radius, ACCESS LYNX demand response service will be offered as a feeder service to fixed-route or as direct transport. Applicants who cannot access fixed route bus system must demonstrate why through a functional assessment.

#### **4. DISABILITY.**

As necessary, a functional assessment of the applicant's abilities may be performed. In addition, Travel Training may be offered if the applicant needs assistance in learning how to navigate the fixed-route system. Finally, if the applicant cannot use LYNX fixed route, ACCESS LYNX demand response service will be offered.

#### **5. INDIVIDUAL AND HOUSEHOLD INCOME STATUS ARE AT OR BELOW SPECIFIED PERCENT OF POVERTY LEVEL.**

The current Federal Income Poverty Guidelines Table will be utilized. Documentation verifying income status will be requested. The applicant's household income must be below 150% of the Federal Poverty Level based on the number of individuals within the household.

\* While there are five criteria listed within this eligibility section, the availability of fixed-route service is currently the only criteria being enforced by ACCESS LYNX to certify passengers as eligible for Transportation Disadvantaged service. An eligibility criteria task force is currently being created to review the TD eligibility criteria and provide recommendations on the certification process.

**TAB 3**



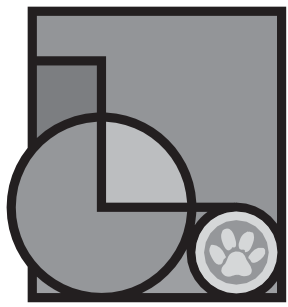


**Transportation Disadvantaged (TD) Program – List of Peer Agencies**

1. Polk County – Citrus Connection
2. Lake County – LakeXpress
3. Palm Beach – Palm Tran Connection
4. Hillsborough – HART
5. Miami-Dade – Miami-Dade Transportation

**TAB 4**

---



# ACCESS LYNX

## PARATRANSIT PARTNERSHIP

### ACCESS LYNX ELIGIBILITY APPLICATION FOR PARATRANSIT SERVICES

#### Instructions to Applicant or Proxy:

1. Please read the enclosed paratransit eligibility criteria carefully. If you feel that you meet these criteria, please fill out the Applicant sections of this form.
2. Please be sure to print and complete all information requested and sign where appropriate.
3. Have the Professional Verification section completed and signed by an approved health care professional. All provided information will be verified and confirmed. You may attach supporting documentation.
4. Completing this application does not automatically certify you for paratransit services. Some applicants may be required to go through a functional assessment to assist us in determining your level of eligibility. All applicants will be notified by mail of the outcome of their application.

**WHEN COMPLETED, PLEASE RETURN THIS FORM TO:**

**ACCESS LYNX  
455 N Garland Avenue  
Orlando, Florida 32801-1518  
Attention: Eligibility  
Phone: (407) 423-8747 - Select Option 6  
Fax: (407) 849-6759**

Applicant Name \_\_\_\_\_

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

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Social Security Number

\_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Medicaid Number

\_\_\_\_\_  
Last Name First Name Middle Initial M/F

\_\_\_\_\_  
Home Address Apartment Number

\_\_\_\_\_  
City County State Zip Code

\_\_\_\_\_  
Complex/Subdivision/Facility Name Nearest Intersecting Street Nearest Bus Route

If this is a gated community, please provide Gate Code \_\_\_\_\_

\_\_\_\_\_  
Home Phone Work Phone Cell Phone E-Mail Address

\_\_\_\_\_  
Mailing Address Apt. Number City County State Zip Code

\_\_\_\_\_  
Emergency Contact Name Relationship Phone Number

\_\_\_\_\_  
Address Apt. Number City County State Zip Code

**Please check all that apply to you.**

\_\_\_\_ Portable Oxygen      \_\_\_\_ Assist Walking      \_\_\_\_ Needs Escort      \_\_\_\_ Wheelchair

\_\_\_\_ Sight Impairment      \_\_\_\_ Cane      \_\_\_\_ Crutches      \_\_\_\_ Walker

\_\_\_\_ Service Animal      \_\_\_\_ Stretcher      \_\_\_\_ Mental Imp.      \_\_\_\_ Hearing Loss

Do you have weekly scheduled medical appointments? \_\_\_\_\_

How many medical appointments do you have in a month? \_\_\_\_\_

How do you currently travel to your destination?

\_\_\_\_ LYNX Bus      \_\_\_\_ Taxi      \_\_\_\_ Drive yourself      \_\_\_\_ Other



Do you have relatives or friends who can take you? \_\_\_\_\_

What is your annual household income? \_\_\_\_\_

How many people, including yourself, are in your household? \_\_\_\_\_

Have you, in the past 2 years, qualified for public assistance? \_\_\_\_\_

Would you ride the bus if you were provided with a bus pass? \_

How far is the nearest bus stop? \_\_\_\_

Do you currently have a LYNX Advantage ID card? \_\_\_\_ Yes \_\_\_\_\_ No

### Functional Ability

Without the assistance of someone else, can you:

Board a bus?	Yes	No	Read/understand directions?	Yes	No
Handle coins and transfers?	Yes	No	Travel on a sidewalk?	Yes	No
Travel to nearest bus stop?	Yes	No	Stand at a bus stop?	Yes	No
Identify the correct bus?	Yes	No	Walk $\frac{3}{4}$ mile?	Yes	No
Climb a 12 inch step?	Yes	No	Cross a street?	Yes	No
Balance while seated?	Yes	No	Grip handles and railings?	Yes	No
Give address and phone number?	Yes	No	Recognize landmarks?	Yes	No
Wait outside for more than 15 minutes?	Yes	No	Travel through crowds?	Yes	No

Please check the condition(s) which prevents you from accessing a regular LYNX fixed route bus.

\_\_\_\_ None.

\_\_\_\_ The bus stop is too far or the bus does not run where I need to go.

\_\_\_\_ My disability prevents me from using the regular fixed route bus system.

\_\_\_\_ I need transportation to and from medical appointments only.

Applicant Name \_\_\_\_\_

**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.

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 \_\_\_\_\_