Exhibit 1

# 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** | 7/1/2020 |

| Budget Allocation | |
|---|---|
| Grant Amount – State Allocation [90%] | $4,593,446.00 |
| Grant Amount – Local Match [10%] | $510,383.00 |
| Grant Amount – Hold Harmless [90%] | $0.00 |
| Grant Amount – Hold Harmless Match [10%] | $0.00 |
| Voluntary Dollar Amount | $464.00 |
| Local Match for Voluntary Dollars [In Kind] | $52.00 |
| ***Total Project Amount*** | **$5,104,345.00** |

| 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 2020-21 Program Manual and Application Instructions 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, 2020 |

| Grant Agreement Service Rates | | |
|---|---|---|
| **Type of Service Transportation Mode** | **Unit of Measure (Trip or Passenger Mile)** | **Cost Per Unit** |
| * Ambulatory | Trip | 18.49 |
| * Wheel Chair | Trip | 31.69 |
| * Stretcher | | |
| Bus Pass – Daily | Pass | |
| Bus Pass – Weekly | Pass | |
| Bus Pass – Monthly | Pass | 70.00 |
| Bus Pass - Monthly Reduced | Pass | 40.00 |
| | | |
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| | | |
| | | |

**** 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.

# 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:**

- (•) Governmental
- ( ) Private Non-Profit
- ( ) Private For Profit

**NETWORK TYPE:**

- ( ) Fully Brokered
- (•) Partially Brokered
- ( ) 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 **2018** to Sept 30th of **2019** | Current Year's **APPROVED** Budget, **as amended** from Oct 1st of **2019** to Sept 30th of **2020** | Upcoming Year's **PROPOSED** Budget from Oct 1st of **2020** to Sept 30th of **2021** | % 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 | | | | | | |
| County Cash | $ 27,315,308 | $ 29,600,000 | $ 31,968,000 | 8.4% | 8.0% | |
| 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 | $ 4,430,595 | $ 4,593,446 | $ 4,593,446 | 3.7% | 0.0% | 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 **2018** to Sept 30th of **2019** | Current Year's **APPROVED** Budget, **as amended** from Oct 1st of **2019** to Sept 30th of **2020** | Upcoming Year's **PROPOSED** Budget from Oct 1st of **2020** to Sept 30th of **2021** | % 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 | | | | |
| **Total Revenues =** | **$31,805,796** | **$34,193,446** | **$36,561,446** | **7.5%** | **6.9%** | |

**EXPENDITURES** (CTC/Operators ONLY / Do **NOT** include Coordination Contractors!)

| | | | | | |
|---|---|---|---|---|---|
| **Operating Expenditures** | | | | | |
| Labor | $ 727,370 | $ 860,790 | $ 886,614 | 18.3% | 3.0% |
| Fringe Benefits | $ 239,377 | $ 307,880 | $ 317,116 | 28.6% | 3.0% |
| Services | $ 78,765 | $ 60,000 | $ 60,000 | -23.8% | 0.0% |
| Materials and Supplies | $ 117,395 | $ 232,970 | $ 239,959 | 98.4% | 3.0% |
| Utilities | | | | | |
| Casualty and Liability | | | | | |
| Taxes | | | | | |
| Purchased Transportation: | | | | | |
| Purchased Bus Pass Expenses | | | | | |
| School Bus Utilization Expenses | | | | | |
| Contracted Transportation Services | $ 30,642,889 | $ 32,731,806 | $ 35,057,757 | 6.8% | 7.1% |
| Other | | | | | |
| 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 =** | **$31,805,796** | **$34,193,446** | **$36,561,446** | 7.5% | 6.9% |

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

# 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 **2020** to Sept 30th of **2021** | 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 | 2 | 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 | $ - | $ - | $ - | | |
| County Cash | $ 31,968,000 | | $ 31,968,000 | | |
| 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 | $ 4,593,446 | $ 4,593,446 | $ - | $ - | $ 510,383 |
| 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*

| 1 | Upcoming Year's **BUDGETED** Revenues from Oct 1st of **2020** to Sept 30th of **2021** 2 | 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? 3 | Budgeted Rate Subsidy Revenue **EX**cluded from the Rate Base 4 | 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? 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 =** | **$ 36,561,446** | **$ 4,593,446** | **$ 31,968,000** | **$ -** |

**EXPENDITURES** (CTC/Operators ONLY)

| | |
|---|---|
| **Operating Expenditures** | |
| Labor | $ 886,614 |
| Fringe Benefits | $ 317,116 |
| Services | $ 60,000 |
| Materials and Supplies | $ 239,959 |
| Utilities | $ - |
| Casualty and Liability | $ - |
| Taxes | $ - |
| Purchased Transportation: | |
| Purchased Bus Pass Expenses | $ - |
| School Bus Utilization Expenses | $ - |
| Contracted Transportation Services | $ 35,057,757 |
| Other | $ - |
| 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 =** | **$ 36,561,446** |
| *minus* **EXCLUDED** Subsidy Revenue = | $ 31,968,000 |
| Budgeted Total Expenditures **INCLUDED** in Rate Base = | $ 4,593,446 |
| Rate Base Adjustment[1] = | |
| **Adjusted Expenditures Included in Rate Base =** | **$ 4,593,446** |

**$ 31,968,000**

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: **2018 - 2019**

***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 = | 3,239,543 |
| **Rate Per Passenger Mile =** | **$ 1.42** |
| Total Projected **Passenger** Trips = | 217,419 |
| **Rate Per Passenger Trip =** | **$ 21.13** |

**Fiscal Year**

**2020 - 2021**

**Avg. Passenger Trip Length = 14.9 Miles**

**Rates If No Revenue Funds Were Identified As Subsidy Funds**

| | |
|---|---|
| **Rate Per Passenger Mile =** | **$ 11.29** |
| **Rate Per Passenger Trip =** | **$ 168.16** |

***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 |
| | | | 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? | Leave Blank | Leave Blank | | |
| 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: 2020 - 2021**

| | | Ambul | Wheel Chair | Stretcher | Group | |
|---|---|---|---|---|---|---|
| | | | | Leave Blank | Leave Blank | |
| **Projected Passenger Miles (excluding totally contracted services addressed in Section II) =** | 3,239,543 = | 2,591,634 + | 647,908 + | + | 0 | |
| **Rate per Passenger Mile =** | | **$1.24** | **$2.13** | **$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) =** | 217,419 = | 173,935 + | 43,484 + | + | + | |
| **Rate per Passenger Trip =** | | **$18.49** | **$31.69** | **$0.00** | **$0.00** per passenger | **$0.00** per group |

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 =** | **$1.24** | **$2.13** | **$0.00** | **$0.00** per passenger | **$0.00** per group |

**Rates If No Revenue Funds Were Identified As Subsidy Funds**

| | Ambul | Wheel Chair | Stretcher | Group | |
|---|---|---|---|---|---|
| **Rate per Passenger Mile =** | **$9.88** | **$16.93** | **$0.00** | **$0.00** per passenger | **$0.00** per group |
| **Rate per Passenger Trip =** | **$147.14** | **$252.24** | **$0.00** | **$0.00** per passenger | **$0.00** per group |

**Program These Rates Into Your Medicaid Encounter Data**

# 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 trip or bus pass funded by the Transportation Disadvantaged Trust Fund. 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, 2021.

6. The Grantee recipient is aware that the approved project must be complete by June 30, 2021, 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

# 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 2020 Federal Poverty Guidelines |
|---|---|
| 1 | $ 28,710.00 |
| 2 | $ 38,790.00 |
| 3 | $ 48,870.00 |

*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)

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**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.

Rev 2/20

# 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 2020 Federal Poverty Guidelines |
|---|---|
| 1 | $ 28,710.00 |
| 2 | $ 38,790.00 |
| 3 | $ 48,870.00 |

*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)

| Broward County Transit | | |
|---|---|---|
| April 9, 2020 | **Paratransit** | Number #2<br>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:**

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. One OR more of the following criteria are met:
   a. Physical OR Cognitive Disability
   b. Age (65 or older)
   c. Household income is equal to or less than 225% of the federal poverty level.
   d. The applicant is unable to provide transportation for self.

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, 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 Income Statement (DEO)
    iv. Current Social Security Award Letter (SSA / SSI / SSDI) or (SSA-1099)
    v. Retirement / Pension / Investment Statement
    vi. Disabled Veteran Benefits Award Letter
    vii. Housing benefits letter (HUD, Section 8, Other) (Attach approval letter)
    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 unable to use fixed route bus independently

        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 the Door to Door Program, 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 Only

        **NM**: No Medical Trips. Applicant currently has a Medicaid program which supplies medical trips. 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

5. 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 DB PROCS- APPLICATION PROCESS LTRS – SELECT DATE FOR PREVIOUS BUSINESS DAY.

    a. Select PRINT
    b. Match printed letter with application source document:

        i. RETURN – Match with source application document and mail
        ii. ELIGIBLE – Letter and *Riders Guide* folded and mail.
        iii. Denial – Non-Eligible – Fold letter
            i. Source application document and appeal letter to Eligibility Specialist for scanning.

6. All documents received (applications, financial, medical forms, etc.) are scanned unless they are duplicates. If they are duplicates, they are shredded.
7. Processed documents are placed in the scan box.

8. 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
a. Save document by Client “lastname_firstname_clientID”

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

| Broward County Transit | | |
|---|---|---|
| April 9, 2020 | **Paratransit** | Number #2<br>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 re-apply every year.

**PROGRAM DESCRIPTION:**

1. The required Transportation Disadvantaged Bus Program application can be obtained by the following ways:
    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 www.Broward.org/bct
    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 criteria is met:
        i. 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, 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 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 Income Statement (DEO)
    d. Current Social Security Award Letter (SSA / SSI / SSDI) or (SSA-1099)
    e. Retirement / Pension / Investment Statement
    f. Disabled Veteran Benefits Award Letter
    g. Housing benefits letter (HUD, Section 8, Other) (Attach letter approval)
    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

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

5. 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.

6. 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)

7. 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.

8. Applicant information is entered into ADEPT database.

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

10. 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.

11. 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, "Not Eligible – Return or Denial". Alphabetize applications within each group.
    b. Open "G" drive – Select ACCESS DB PROCS- APPLICATION PROCESS LTRS – SELECT DATE FOR PREVIOUS BUSINESS DAY.
    c. Select PRINT
    d. Match printed letter with application source document:
        i. RETURN – Match with source application document and mail
        ii. DENIAL – Fold and mail letter

12. Source application document and appeal letter to Eligibility Specialist for scanning.
13. All documents received (applications, financial, medical forms, etc.) are scanned unless they are duplicates. If they are duplicates, they are shredded.
14. Processed documents are placed in the scan box.
15. 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 "lastname_firstname_clientID"

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