



Dear Transportation Disadvantaged Program Applicant:

Florida’s Transportation Disadvantaged (TD) Program was established with the passage of Chapter 427, Florida Statutes. The TD Program assists individuals who are unable to transport themselves or purchase transportation services due to a physical or mental disability, income, and/or age. MTM Transit is the designated Community Transportation Coordinator (CTC) for DeSoto, Hardee, Highlands, and Okeechobee Counties. We are responsible for determining if applicants are eligible for the TD Program. We collect information from applicants to determine what services you are eligible for. All services are demand response, which means we must also have rider information for you.

Effective July 1, 2021, you must provide proof of at least one of the following criteria to qualify for the TD Program and other available funding programs:

1. **You are unable to transport yourself.** This means you are unable to drive a vehicle due to a physical or mental disability. You must provide medical verification of your disability from your physician.
2. **You are unable to purchase transportation.** This means your income must meet a maximum of 150% of the current Federal Poverty Guidelines. You must provide proof of income.
3. **You are unable to obtain transportation.** This means you do not have an operational vehicle in your household, the ability to operate a vehicle safely, or the ability to find transportation from other sources. You also may not be sponsored by any other agency for transportation.
4. **You are older than 60 years old.** You must provide proof of your age, such as a driver’s license, birth certificate, or photo ID that shows your date of birth.

To apply for the TD Program, please complete the enclosed application. Return your completed application to MTM Transit via mail, fax, or email:

**Mail**  
 MTM Transit  
 Attention: Scheduling Team  
 4650 US Hwy 27 South  
 Sebring, FL 33870

**Fax**  
 1-863-382-8469

**Email**  
 HeartlandAccess@mtm-inc.net

If you have any questions or need help completing this form, please call us. Please allow up to five business days for MTM Transit to receive and process your request. After five business days, please contact MTM Transit to confirm that your application has been processed and to schedule your ride:

**Avon Park:** 863-452-0139

**Sebring:** 863-382-0139

**Lake Placid:** 863-699-0995

**Okeechobee:** 863-357-9900

**DeSoto:** 800-694-6566

**Hardee:** 863-773-0015

**Toll-Free:** 800-260-0139

Thank you for your interest in the TD Program. We look forward to helping you access your community!



The information contained in this application will be used by MTM Transit to determine your eligibility for transit services. MTM Transit is responsible for coordinating and/or providing transportation services to individuals who are transportation disadvantaged. You are considered transportation disadvantaged if, because of age, income, or a disability, you cannot drive and do not have access to other transportation options. Eligibility is determined based on age, income, or any disability, as well as by the system’s budget constraints in each county. **Your application must be renewed every two years.**

Date: \_\_\_\_\_
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_
Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_
City: \_\_\_\_\_ Zip Code: \_\_\_\_\_
County: \_\_\_\_\_ Phone #: \_\_\_\_\_
DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: [ ] Female [ ] Male
Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Please provide directions to your home: \_\_\_\_\_

- 1. Do you receive food stamps? [ ] Yes [ ] No
2. Do you have Medicaid? [ ] Yes [ ] No
a. If yes, provide your Medicaid ID number: \_\_\_\_\_
3. How many family members live in your home? \_\_\_\_\_
4. What is your annual income? \$\_\_\_\_\_
5. Do you live in an assisted living facility, nursing home, retirement home, or boarding home? [ ] Yes [ ] No
6. Do you have relatives or friends who live nearby and would transport you if you asked? [ ] Yes [ ] No
7. Is your condition or disability temporary? [ ] Yes [ ] No
a. If yes, what is the duration of your condition? \_\_\_\_\_ weeks/months (circle one)

You must provide medical verification of your disability from your physician.

- 8. Do you use any mobility aids? Check all that apply.
[ ] Power Wheelchair [ ] Manual Wheelchair [ ] Walker [ ] Cane
[ ] Power Scooter [ ] Service Animal [ ] Crutches



9. Can you travel without assistance the following distances?

200 feet  Yes  No      1/4 mile  Yes  No      1/2 mile  Yes  No

10. Can you climb a 12-inch step with assistance?  Yes  No

11. Can you climb a 12-inch step without assistance?  Yes  No

12. Are you able to stand outside without support for at least 20 minutes?  Yes  No

13. Can you give an address and telephone number upon request?  Yes  No

14. Can you recognize a destination or landmark?  Yes  No

15. Can you understand and follow directions?  Yes  No

16. Can you handle unexpected situations or changes in your routine?  Yes  No

17. Can you safely and effectively travel through a crowded or complex facility?  Yes  No

18. Are you legally blind or do you have a vision impairment?  Yes  No

19. Are you deaf or significantly hearing impaired?  Yes  No

20. Do you have a personal care assistant who assists you when you travel?  Yes  No

I understand and affirm that the information provided in this application for Non-Emergency Transportation Disadvantaged services is true and correct to the best of my knowledge and will be kept confidential and shared only with medical and transportation professionals involved in evaluating and determining my needs and eligibility for transportation to and from eligible services as well as appointments. I understand that providing false or misleading information or making fraudulent claims or making false claims on behalf of others could constitute a felony under the laws of the State of Florida.

Applicant Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_

Preparer's Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Preparer's Signature: \_\_\_\_\_

Date Prepared: \_\_\_\_\_

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MTM USE ONLY

Date Received:	New Registration: <input type="checkbox"/>	Renewal: <input type="checkbox"/>
Reviewed by:	Approved: <input type="checkbox"/>	Denied: <input type="checkbox"/>
Reason for Denial:		
Approved Funding Sources	TD – Age <input type="checkbox"/>   TD – Income <input type="checkbox"/> TD – Disability <input type="checkbox"/> Documentation Provided: _____	Section 5310 <input type="checkbox"/>  Section 5311 <input type="checkbox"/>

Signature: \_\_\_\_\_ Date: \_\_\_\_\_