



Return completed applications and supporting documents to:

Mobility Coordinator, 5303 Pinkney Ave, Sarasota FL 34233

Email: eligibility@scgov.net Fax: 941-861-1007

Eligibility-based Programs

Applicant Information

Last Name _____ First Name _____ MI _____

Date of Birth ____ / ____ / _____ Sex M F Language _____

Street Address _____ Apt # _____ Bldg # _____

City _____ State _____ Zip Code _____ Gate Code _____

Phone ____ - ____ - _____ Cell Home Phone ____ - ____ - _____ Cell Home

Email _____

Primary Contact

If transportation services will be arranged through someone other than the applicant listed above, please provide information for the primary contact.

Last Name _____ First Name _____

Phone ____ - ____ - _____ Cell Home Relationship _____

Emergency Contact

Last Name _____ First Name _____

Phone ____ - ____ - _____ Cell Home Relationship _____

ADA Program Application

Applicants for the ADA Program must submit a completed Medical Verification Form (pages 3 & 4).

Please initial each statement, then sign and date.

_____ I understand that intentionally providing false or misleading information may affect my eligibility for ADA services.

_____ To the best of my knowledge, the information provided in this application is correct.

_____ I agree to notify the Mobility Coordinator's office if my condition changes, if I am using a new mobility device, or if I no longer need to use ADA services.

Signature _____ Date _____

For more information, dial 311 (TTY 7-1-1 or 1-800-955-8771) or visit scgov.net/breeze

Revised 2025/08

Transportation Disadvantaged (TD) Program Application

Access to Transportation

How many vehicles are in your household? _____

Are you able to reliably transport yourself, arrange transportation with others, or secure a transportation service? Yes No

How do you currently travel to appointments or other necessary activities?

Additional Qualifying Factors

Applicants for the Transportation Disadvantaged Program must meet at least one of the following criteria. Please check any statement that applies.

I am aged 65 years or older. Applicants selecting this option must **attach a copy of a valid driver's license, state-issued ID card or valid U.S. passport.**

I have a physical or mental disability that prevents me from independently using Breeze bus routes. Applicants selecting this option must **submit a completed Medical Verification Form (pages 3 & 4).**

My household income is 150% or less of the federal poverty level. Applicants selecting this option must **complete the information within this shaded area.**

Annual household income _____ Number of people in my household _____

Attach at least one of the following to demonstrate annual income:

- 1st page of last year's tax return
- DCF cash benefit/child support letter
- Unemployment compensation income verification
- Social Security Income verification or proof of income letter (SSI and SSDI)
- Retirement/pension income statement
- Proof of VA disability income
- IF CLAIMING NO INCOME: proof of food stamp eligibility or a signed letter on agency letterhead verifying the applicant has no income

Please initial each statement, then sign and date.

_____ I understand that intentionally providing false or misleading information may affect my eligibility for ADA services.

_____ To the best of my knowledge, the information provided in this application is correct.

_____ I agree to notify the Mobility Coordinator's office if my condition changes, if I am using a new mobility device, or if I no longer need to use TD services.

Signature _____ Date _____



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Medical Verification Form

Applicants qualifying for the ADA or Transportation Disadvantaged Programs based on a physical or cognitive condition, impairment, or disability, must include this form with their application. This form must be completed and signed by a licensed healthcare provider within one of the following fields:

- Medical Doctor (MD)
- Doctor of Osteopathic Medicine (DO)
- Doctor of Chiropractic
- Neurologist
- Audiologist
- Ophthalmologist
- Psychologist
- Psychiatrist
- Speech-Language Pathologist (DLP)
- Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA)
- Occupational Therapist or Physical Therapist
- Licensed Clinical Social Worker (LCSW)

Applicant Section

Last Name _____ First Name _____ MI _____

Date of Birth ____ / ____ / _____

Please initial each statement, then sign and date.

_____ I authorize my healthcare professional to release any and all information about my disability or health condition and its effect on my ability to transport myself or to secure transportation, including the use of Breeze bus routes.

_____ I understand that to confirm this information, the Mobility Coordinator's office may contact the healthcare provider who completed this Medical Verification Form.

_____ I understand that Breeze will keep all medical information confidential.

_____ I understand that I may revoke this authorization at any time.

Applicant Signature _____ Date _____

Provider Section (to be completed by healthcare professional)

The applicant is seeking approval for the use of Breeze ADA Complementary Paratransit and/or Transportation Disadvantaged services. Eligibility for these services is based on the applicant's functional ability to operate a personal vehicle, independently navigate public transportation (Breeze buses), and/or secure a transportation service. Only medical care providers who have direct knowledge of the applicant's abilities are authorized to complete this form.

Provider's Full Name (printed) _____

Title _____ Medical License Number _____

Office Street Address _____

City _____ State _____ Zip _____ Phone _____

Email _____ Fax _____

Provider Section (continued)

1. Does the applicant have a disability that impacts his or her ability to
 - a. Recognize graphic signs (such as bus stop signs) Yes No
 - b. Communicate addresses, destinations, and phone numbers Yes No
 - c. Read and/or monitor time Yes No
 - d. Ask for, understand, and follow instructions Yes No
 - e. Safely/effectively maneuver ramps, complex facilities, or crowds Yes No
 - f. Wait in an exposed outdoor space for up to 30 minutes Yes No
 - g. Adjust to unexpected situations or changes in routine Yes No

2. Does the applicant require any of the following mobility aids?

<input type="checkbox"/> Powerchair	<input type="checkbox"/> Walker	<input type="checkbox"/> Braces
<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Cane	<input type="checkbox"/> Oxygen
<input type="checkbox"/> Powered scooter	<input type="checkbox"/> Crutches	

3. Does the applicant require a Personal Care Attendant (PCA) while traveling? Yes No

4. Please describe any other medical conditions – including severity, restrictions/limitations, and prognosis – that may limit the applicant’s ability to travel independently.

5. Has the applicant been diagnosed with a disability (cognitive, mental, physical, or other) that prevents him/her from independently navigating public transportation (scheduled buses that operate on fixed routes)? Yes No

If yes, please list each disability and describe its impact on the applicant’s ability to travel independently.

Disability	Impact	Date of Diagnosis	Duration of Diagnosis
			<input type="checkbox"/> Temporary <input type="checkbox"/> Permanent
			<input type="checkbox"/> Temporary <input type="checkbox"/> Permanent
			<input type="checkbox"/> Temporary <input type="checkbox"/> Permanent
			<input type="checkbox"/> Temporary <input type="checkbox"/> Permanent
			<input type="checkbox"/> Temporary <input type="checkbox"/> Permanent

Provider Signature _____ Date _____