Polk County Transportation

APPLICATION FOR ELDERLY AND DISABLED TRANSPORTATION ASSISTANCE (EDTAP)

This form is to be completed annually by Polk County residents of any age to apply for grant funded transportation when they have a certifiable disability which substantially limits one or more major life activity. EDTAP is open to persons with limited income, which may be verified when an application is submitted. All others are welcome to ride at any time by paying the appropriate fare. The provisions of this program are subject to change based on the availability of funding, equipment and personnel.

Submit applications to:

PCT 3 Courthouse Square, P.O. Box 308, Columbus, NC 28722 Phone: 828-894-8203, Fax: 828-894-5913

Passenger Information

First Name	Middle Name	Last Name
Date of Birth	Last 4 Digits SS#	Email Address
Physical Address		
Mailing Address (If different)		
Home Phone	Work Phone	Cell Phone
Emergency Contact Name	Phone Number	Alternate Number

Passenger Demographic Information

Gender: (Check one) ◯ Female ◯ Male

Marital Status: (Check one) ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Primary Language: (Check one) ◯ English ◯ Spanish ◯ Other (specify)

Type of Disability – What is the nature of the disability which substantially limits one or more major life activity?

___ Mental ___ Physical ___ Vision ___ Hearing ___ Other (Specify)

Mobility Aid – Which of the following devices do you use? __ Walker ___ Cane __ Oxygen __ Other _____

__ Wheelchair: Type of wheel chair you use – e.g. manual, Jazzy, Bariatric Motorized.

Is your home accessible by ramp? Y___ N___	Accompanied by other adults or children when travelling? Y___ N___ Number of children under 8 years old who travel with you?

Do you receive transportation services or funds from any other agency? ____ Yes ____ No

Specify:

Are you served by any of the following agencies? Check all that apply.

Department of Social Services (DSS)		Substance Abuse	
Vocational Rehab		Dialysis	
Mental Health		DSS Work First	
Health Department		Hospice	
Veterans Affairs		Other (specify)	

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Applicant Income

Total number in your household :

Total household yearly income:

Total number of dependent children:

Are you claimed as a dependent by someone else? ____ Y ____ N

2018 Federal Poverty Level

Number in Household	100%	150%	200%	250%
1	$ 12,140	$ 18,210	$ 24,280	$ 30,350
2	$ 16,460	$ 24,690	$ 32,920	$ 41,150
3	$ 20,780	$ 31,170	$ 41,560	$ 51,950
4	$ 25,100	$ 37,650	$ 50,200	$ 62,750
5	$ 29,420	$ 44,130	$ 58,840	$ 73,550
6	$ 33,740	$ 50,610	$ 67,480	$ 84,350
7	$ 38,060	$ 57,090	$ 76,120	$ 95,150
8	$ 42,380	$ 63,570	$ 84,760	$ 105,950

Add $4,320 for each additional person when there are more than eight in the household

Disability Certification to be Signed by a Medical Professional if Applicant is Under 60 Years Old

I, _____ do hereby certify that the applicant has a physical or mental impairment that substantially limits one or more major life activity or is an individual who has a record of such impairment, or is an individual who is regarded as having such an impairment.

Is the disability temporary or permanent? _____ Length of disability _____

Name of Medical Professional (Print) _____

Designation/Title _____

Business Address _____

Phone Number _____

Signed _____ Date _____

By signing this document I affirm that all information provided is true and accurate.

Passenger Signature _____ Date _____

Date Received	Date Reviewed	Date Approved:	Follow Up Date and Notes

Reviewed by

Approved: _____ Y _____ N

INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED - MUST INCLUDE SIGNATURES AND INCOME.