

# 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) <input type="radio"/> Female <input type="radio"/> Male	Marital Status: (Check one) <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widowed
Primary Language: (Check one) <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> 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 :

### 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

Total household yearly income:

Total number of dependent children:

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

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.**