Lee County
Southwest Florida

Board of County Commissioners

TRANSPORTATION DISADVANTAGED (TD) APPLICATION INSTRUCTIONS

- The applicant or caregiver must complete the TD Program Application.
- The applicant or caregiver must complete the emergency contact form.
- Applicants are **required** to provide proof of the household income.
- Applicants must submit a copy of a government-issued identification that includes their date of birth.
- Completed forms can be submitted by fax, mail, or in person to the address provided below.

Door-to-Door Paratransit Transportation: LeeTran offers door-to-door paratransit services for various essential and life-sustaining activities including healthcare, employment, education, shopping, social activities, and more. Non-essential trips (shopping, recreational, etc.) will be transported to the nearest facility.

Eligibility: The Transportation Disadvantaged (TD) Program is a "last resort" program for individuals with no access to any other transportation resources. TD qualify for TD services, applicants must meet at least two of the following criteria: low income, senior over the age of 60, unable to use fixed route transit due to a disability, lack access to any other means of transportation, and/or live outside the fixed route service area.

TD Recertification: Passengers must renew their eligibility for the TD program **every two years** to maintain active status.

Submit a Complete Application: It is mandatory to submit a complete application with all required supporting documentation. Applications with missing information or blanks may delay the eligibility determination process. Applicants must provide the following: A valid government-issued identification. Applicable financial documents to verify income (**self-declaration of income is not accepted**). Any required medical information to support eligibility.

Every effort is made to verify the information submitted to ensure compliance and accuracy.

Acceptable forms of proof of income include:

Current tax return	Unemployment compensation income verification
Child support letter	Social security income letter (SSA, SSI, SSDI)
Minimum of two (2) employer pay stubs from past two months	Retirement/pension statement (includes VA)
Agency Verification Letter – Must be on the agency's official letterhead and identify the applicant as low-income or no-income. ***The agency providing this letter must be pre-approved by LeeTran.***	Temporary Assistance for Needy Families (TANF) letter, Supplemental Nutrition Assistance Program (SNAP) letter, or Department of Children & Families (DCF) benefits letter

For more information about the program, please refer to LeeTran's Passport Passenger's Guide at LeeTran Passport Guide. If you have any questions regarding this process, feel free to contact the Passport office at the telephone number listed below.

Accessible formats are available upon request.

PASSPORT a service of leetran

Lee County Transit – LeeTran Passport Services
3401 Metro Parkway
Fort Myers, FL 33901
Phone Number: (239) 533-0300

Revised 10.7.25/REM

Lee County Transit – LeeTran Passport Services
3401 Metro Parkway
Fort Myers, FL 33901
Phone Number: (239) 533-0300
Fax Number: (239) 432-2035

EMERGENCY CONTACT FORM

APPLICANT/PASSENGER'S NAME: _____

EMERGENCY CONTACT NAME: _____

RELATIONSHIP TO APPLICANT: _____

TELEPHONE NUMBER(S): _____

_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TRANSPORTATION DISADVANTAGED DETERMINATION FORM

All items must be completed and TYPED or PRINTED legibly or form will not be processed

SECTION I – IDENTIFYING INFORMATION

Last Name: _____First Name: _____M.I.___
Home Address: _____ Apt.# _____
Is this a: ☐ House ☐ Apartment ☐ Nursing Facility ☐ ACLF ☐ Boarding Home
City: _____ State: _____ Zip Code: _____
Date of Birth: _____/_____/_____ Your Current Age: _____ ☐ Male ☐ Female
Phone Number: (____)_____ Email address: _____
Medicaid Number: _____
Total Monthly Income: _____ **(Must provide proof of household income)**

SECTION II – NEED DETERMINATION

Are you able to operate an automobile, even for short distances? ☐ Yes ☐ No
Do you or anyone in your household own a car? ☐ Yes ☐ No
What is your license plate(s) number(s)? _____ _____
_____ _____

Total # of persons who reside in your household? _____ Please list below:

Name	Is this person Related to you?	Does this person own own a car?
_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	☐ Yes ☐ No	☐ Yes ☐ No

If you live in an Assisted Care Living Facility, Nursing Home, ICFMR, or Boarding Home does this facility have a vehicle? ☐ Yes ☐ No
Have you ever been transported by the facility? ☐ Yes ☐ No
Do you have any family or friends who live in the County you reside in? ☐ Yes ☐ No
Has this person(s) ever transported you to the doctor? ☐ Yes ☐ No
Would this person(s) take you to the doctor if you asked them? ☐ Yes ☐ No
Do you know someone who would transport you if you paid for the gas? ☐ Yes ☐ No
Have you ever taken the LeeTran bus to the doctor or to other places? ☐ Yes ☐ No
Can you travel on a LeeTran bus? ☐ Yes ☐ No
If NO, please explain why:

_____

Would you use the LeeTran bus if you could ride for free? ☐ Yes ☐ No

Can you walk without help to the distances below? (Check those that apply)
☐ Across a room ☐ One block ☐ Two blocks ☐ Three blocks ☐ One mile

SECTION III – DISABILITY

Are you currently receiving Supplemental Security Income (SSI)? ☐ Yes ☐ No
Are you currently receiving Social Security Disability? ☐ Yes ☐ No
Do you consider yourself to be disabled? ☐ Yes ☐ No

If yes, what is the nature of your disability? (Check all that apply)
☐ Blind/Legally Blind ☐ Wheelchair User ☐ Difficulty Walking ☐ Arthritis
☐ Cerebral Palsy ☐ Multiple Sclerosis ☐ Neuromuscular Disease ☐ Stroke
☐ Alzheimer's Disease ☐ Epilepsy ☐ Respirator or Oxygen Dependent
☐ Muscular Dystrophy ☐ Mentally Challenged ☐ Emotionally Challenged
☐ Other (describe)
_____

Do you require mobility aids? ☐ Yes ☐ No
If YES, which aids do you require? Check all that apply?
☐ Walker ☐ Guide Dog ☐ Personal Care Attendant ☐ Scooter ☐ Cane ☐ Oxygen
☐ Wheelchair ☐ Other _____

SECTION IV – FREQUENCY OF USE/DESTINATIONS

What doctors or medical clinics do you visit on a regular basis?

NAME AND ADDRESS OF HOSPITAL, DOCTOR OR CLINIC	**NUMBER OF VISITS EACH MONTH OR WEEK**

SECTION V – SIGNATURE, PREPARER, AND WITNESS

I affirm that the information provided in this application for services is true and correct and understand that making false statements, having others make false statements, or making false statements on behalf of others constitutes fraud and is considered **a felony under the laws of the State of Florida.**

Transportation Disadvantaged Recipient's

Signature: _____ Date: _____

Preparer's Signature: _____ Date: _____