



ACCESS LYNX
AMERICANS WITH DISABILITIES
ACT (ADA) PROGRAM

Thank you for your interest in the Americans with Disabilities Act (ADA) program which is a shared-ride door to door service provided to eligible residents of Orange, Osceola, and Seminole counties.

Please be sure to complete all information requested and sign where appropriate. The Medical section must be completed and signed by a Licensed Professional (familiar with your disability or health condition and your functional abilities). If necessary, further information may be requested to determine eligibility.

Recertification Requirements:

Permanent (continued) Eligibility – Automatic recertification will be considered for individuals who cannot use LYNX bus service under any circumstances and/or whose disability is unlikely to improve. Customers who have been provided permanent eligibility will receive a verification document to update/recertify their information and note any changes in their travel abilities or needs **every three years from date of the initial eligibility.**

Standard Eligibility - All customers granted approval under this category (unconditional/conditional) will be required to recertify **every two years from date of the initial eligibility.**

Temporary Eligibility - All customers granted approval under this category will be required to recertify based on the length of time granted in the approval.

Customers that are ADA eligible with another transit provider may use ACCESS LYNX by providing documentation of their eligibility status prior to needing to travel. This same right applies to ACCESS LYNX customers traveling to other communities that offer complimentary ADA paratransit services.

Disclaimer: Completing this application does not automatically certify you for paratransit services. Some applicants may be required to go through a functional assessment to assist us in determining your level of eligibility. All applicants will be notified by mail of the outcome of their application. Processing may take up to 21 days from receipt of a completed application to include completion of a Functional Assessment if required.

Mail Completed Application to:
ACCESS LYNX (Eligibility)
455 N Garland Ave.
Orlando, FL 32801

Fax Application to: (407) 849-6759

Information: (407) 423-8747 (select Option 6)



Central Florida Regional Transportation Authority

455 N. Garland Avenue | Orlando | Florida | 32801 | www.golynx.com

FOR OFFICE USE ONLY:	DATE RECEIVED _____
Client ID: _____	NEW _____ RECERT _____ PERM ELIG _____

APPLICATION: General Information (SECTION 1)

_____	_____	_____	_____		
Date of Birth	Last 4 of Social Security Number				
_____	_____	_____	_____		
Last Name	First Name	Middle Initial	M/F		
_____	_____				
Home Address	Apartment Number				
_____	_____	_____	_____		
City	County	State	Zip Code		
_____	_____				
Complex/Subdivision/ Facility Name	Gate Code				
_____	_____	_____	_____		
Home Phone	Work Phone	Cell Phone	Email address		
_____	_____	_____	_____		
Mailing Address	Apt Number	City	County	State	Zip Code

Emergency Contact:

_____	_____	_____		
Name	Relationship	Phone number		
_____	_____	_____		
Address / Apt Number	City	County	State	Zip Code

Please check all that apply to you:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Service Animal | <input type="checkbox"/> Walker | <input type="checkbox"/> Portable Oxygen | <input type="checkbox"/> Power Scooter |
| <input type="checkbox"/> Cane | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Mental Impairment | <input type="checkbox"/> Mental Impairment (Do not Leave Unattended) |
| <input type="checkbox"/> Sight Impairment | <input type="checkbox"/> Deaf | <input type="checkbox"/> Manual Wheelchair | |
| <input type="checkbox"/> Blind/Legally Blind | <input type="checkbox"/> Need Attendant | <input type="checkbox"/> Power Wheelchair | |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Assist Walking | <input type="checkbox"/> Wide Wheelchair | <input type="checkbox"/> Personal Care Attendant |



How do you currently travel to your destination?

LYNX (City bus/NeighborLink) Taxi TNC Drive yourself Other

Would you ride the bus if you were provided with a bus pass? Yes No

Do you currently have a LYNX Advantage ID card? Yes No

Functional Ability

Without the assistance of someone else, can you:

Board a bus?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Read/understand directions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Handle coins and transfers?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Travel on a sidewalk?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Travel to nearest bus stop?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stand at a bus stop?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Identify the correct bus?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Walk ¾ mile?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Climb a 12 inch step?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cross a street?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Balance while seated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Grip handles and railings?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Give address and phone number?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recognize landmarks?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wait outside for more than 15 minutes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Travel through crowds?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Applicant's Release: (SECTION 2)

I understand that the purpose of this evaluation form is to determine my eligibility for ADA Service. I understand that the information about my disability contained in this application will be kept confidential and shared only with professionals involved in evaluating my eligibility. I hereby authorize my medical representative to release any and all information regarding my medical condition to LYNX as it applies to this evaluation.

I understand that providing false or misleading information could result in my eligibility status being revoked. I agree to notify ACCESS LYNX within 10 days if there is any change in circumstances or I no longer need to use the transportation services.

Signature of Applicant

Date

Signature of Preparer (if other than applicant)

Date

Print Name (Preparer)

Relationship



Medical Form (SECTION 3)

Instructions for Licensed professional (familiar with your disability or health condition and your functional abilities): Please complete the section below. The information that you provide must be based solely upon the applicant having an actual physical or mental impairment that substantially limits one or more major life activities.

Applicant Name: _____ Date of Birth: _____

What is the applicant's disability or condition and how does it prevent him/her from using LYNX?

- Cognitive Impairment Functional Hearing Visual
 Uncontrolled Fatigue Emotional Neurological

Other – Explain: _____

Is the applicant's disability or condition Permanent? Temporary?

If Temporary, what is duration? _____

Are any of the following affected by the individual's disability? (Check all that apply)

- Orientation Monitoring time Gait or balance
 Problem Solving Judgment Inconsistent performance
 Short-term Memory Communication Long-term memory
 Inappropriate social behavior Do Not Leave Unattended

Other (please explain) _____

If applicant is currently taking prescribed medication(s), does this medication enhance or diminish the individual's functional ability to travel independently? Yes No

If yes, please explain. _____

I, the undersigned, certify the medical information provided on the ADA Application is true and correct. I understand providing false or misleading information constitutes fraud and is considered a felony under the laws of the State of Florida.

Licensed Professional's Signature

Medical License Number

Licensed Professional's Name (Print Legibly)

Contact Number

Contact Address

