



304 Druid Hills Road  
 Temple Terrace, FL 33617  
 ADT Tel 813.919.5543  
 Transportation Tel 813.538.6798  
[transportation@focusforwardtampa.com](mailto:transportation@focusforwardtampa.com)

**Focus Forward Transportation Application**

**General Information**

Applicant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

**Transportation Services Needed**

Pick-up/Drop-off  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

How many miles is the pick-up/drop-off address from Focus Forward  
 (304 Druid Hills Road)? \_\_\_\_\_

If the pick-up/drop-off address is outside of a 10 mile radius, would you be willing to find a central location to drop your young adult off in the mornings and pick them up from in the afternoons? Circle one. Yes No

Indicate the schedule for services you would like your young adult to be receiving services for.  
 AM indicates client needs transportation from their homes to Focus Forward at the beginning of program hours and  
 PM indicates client needs transportation from Focus Forward to their homes at the end of program hours.

| Monday                        | Tuesday                       | Wednesday                     | Thursday                      | Friday                        |                                    |
|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|------------------------------------|
| <input type="checkbox"/> AM   | <input type="checkbox"/> AM   | <input type="checkbox"/> AM   | <input type="checkbox"/> AM   | <input type="checkbox"/> AM   |                                    |
| <input type="checkbox"/> PM   | <input type="checkbox"/> PM   | <input type="checkbox"/> PM   | <input type="checkbox"/> PM   | <input type="checkbox"/> PM   | <input type="checkbox"/> OTHER     |
| <input type="checkbox"/> BOTH | <input type="checkbox"/> BOTH | <input type="checkbox"/> BOTH | <input type="checkbox"/> BOTH | <input type="checkbox"/> BOTH | <input type="checkbox"/> AS-NEEDED |

## Payment Method Preference

Please indicate which method of payment you will be using to pay for our transportation services. Remember that transportation will be billed for each week.

**MEDICAID**

(if Medicaid, please provide additional information)

Name of Support Coordinator:

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Phone number of Support Coordinator:

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Email of Support Coordinator:

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**DEVELOPMENTAL DISABILITIES MANAGED CARE PILOT PROGRAM**

(if Pilot Program, please provide additional information)

Name of Care Coordinator:

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Phone number of Care Coordinator:

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Email of Care Coordinator:

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**SELF PAY**

(if self-pay, please select the specific method)

Cash

Check

Square (please note a square surcharge will be applied)

**SELF PAY RATES**

One way: \$25.00

Two ways: \$50.00

Full Week One Way: \$250.00

Full Week Two Ways: \$500.00