Application Disability Transit Eligibility

PLEASE READ BEFORE COMPLETING THIS APPLICATION

Dear Applicant:

The questions in PART A of this application represent the first step in the process to certify your application for eligibility to use HCT Para Transit Service. Please answer each question because the answer will assist use in determining the appropriate service to match your abilities. **HAVING A DISBILITY DOES NOT AUTOMATICALLY MAKE SOMEONE ELIGIBILITY FOR PARATRANSIT SERVICE.** Eligibility is determined based on how the disability restricts the applicant to travel to and ride the regular (big), fixed route bus. **ALL QUESTIONS ON THIS APPLICATION ARE REFERRING TO THE REGULAR (BIG) FIXED ROUTE BUS. ALL FIXED ROUTE BUSES ARE WHEELCHAIR ACCESSIBLE.**

It is your responsibility to return the completed, signed PART A and Part 1of Part B portion of the application for the certification process to HCT (See address or fax number below). You must sign Part 1 of Part B of the Medical Release Page of this form, authorizing your Licensed/Certified Health Care Professional to release information about your disability. **On the Medical Release page, please be certain to provide complete information of the Licensed/Certified Health Care Professional who can appropriately answer questions about your disability and your ability to travel.**

Part B must be filled out by your Licensed/Certified Health Care Professional. Your application will be considered complete once your Licensed/Certified Health Care Professional has completed and returned PART B to HCT. HCT will then come to a decision as to your eligibility within 21 business days once the completed application is received. If we don't render a decision within 21 days you will be granted presumptive eligibility until we provide a decision on your application.

Mail application to:

Hub City Transit Operations Center
P.O. Box 1898
Hattiesburg, MS 39403

Fax:
(601) 545-7507

Please note: The person filling out PART A of this application cannot be the same person who will fill out PART B of the Licensed/Certified Health Care Professional.

PART 1 OF PART A

APPLICANT INFORMATION **(PLEASE PRINT)**

Date: _____

Please check one: Initial Application _____ Re- Certification Application_____

Name: _____
First Name MI Last Name

Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

In case of emergency, contact: _____

Emergency contact phone number: _____

Date of Birth: _____ Male: _____ Female: _____

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Please check all types of activities you need transit services for:

_____ Doctor visits _____ Drug Stores _____Grocery Shopping

_____ Recreation _____ Civic Activities

_____Organizational Meetings _____ Volunteer Work

_____ Other

What is the medical name of your disability?
_____

How does this condition affect your ability to ride the regular (big), fixed route bus service?
_____

_____

PART 2 OF PART A

Are there any other physical or mental disabilities that may impact your **FUNCTIONAL ABILITY** to ride the regular (big) fix route bus service?
Yes _____ No _____

If yes, please describe:
_____

_____

Will someone be riding with you on the bus to assist / help you (personal care attendant)?
Yes ____ No _____

Name of PCA_____Phone_____

Which of the following mobility aids do you use? (check all that apply)

_____ Cane _____ Manual Wheelchair _____ Guide animal

_____ White Cane _____Power Wheelchair _____Walker

_____Power Scooter _____ Crutches _____ Portable Oxygen

_____Artificial Limb _____ Hearing Ear Animal

How far can you walk **without** the assistance of another person?

- ☐ Less than 200 feet
- ☐ ¼ mile (3 blocks)
- ☐ ½ mile (6 blocks)
- ☐ ¾ mile (9 blocks)
- ☐ More than ¾ mile (more than 9 blocks)

Are you able to walk up 12-14 inch steps unassisted? Yes _____ No _____

If unassisted, can you grip a handrail to support yourself? Yes _____ No _____

Do you require walking on a lift and gripping the handrail in order to board/exit the bus?
Yes _____ No _____

Can you wait 30 minutes at a location where the HCT will stop, that **DOES NOT** have a seat or shelter? Yes _____No _____

If No, please explain why? _____

_____

Part 1 of Part B

PATIENT CONSENT TO RELEASE & DISCLOSURE OF MEDICAL INFORMATION

This Consent to Release Medical Information is to be provided to:

(PLEASE GIVE COMPLTETE INFORMATION ABOUT THE HEALTH CARE PROFESSIONAL WHO WILL VERIFIY YOUR APPLICATION INFORMATION)

NAME_____

ADDRESS_____

CITY_____

PHONE ( ) _____ FAX ( )_____

I, the undersigned, do hereby consent to the release and disclosure of any relevant medical information to HCT Paratransit Services as called for in Part B of this application for the sole purpose to determine ADA paratransit eligibility. I understand that this information will be shared only with the persons making decisions related to my eligibility for paratransit services and to other providers needing such information to facilitate travel.

I have read this document carefully and understand that I have the right to revoke this release in writing, excepting information that may have previously been released under this authorization.

_____ _____

Signature of Applicant, Representative, or Guardian **Date**

If someone other than the applicant has completed this application/authorization, that person must complete the following:

Name: _____

Relationship: _____

Address: _____

Home phone: _____ Work phone: _____

Mail to: **Hub City Transit Operations Center**
P.O. Box 1898
Hattiesburg, MS 39403

Or

Fax: **601-545-7507**

Part 2 of Part B

Medical / Professional Verification
(Not a request for copies of medical records)

Applicants Name: ____

Address: ____

Date of Birth: ________________________
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Please describe the applicant's Disability/Condition in layman's terminology.

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Is the applicants Disability/ Condition Permanent? ____Yes ____No

If temporary, when will the applicant be able to resume normal travel patterns?

Date to resume normal travel: _____________________

Part 3 of Part B

Medical / Professional Verification

How far can the applicant walk without the assistance? Please check all that applies.

_________________ Length of one football field (300 feet)

_________________ Less than one city block (500 feet)

_________________ One length of a football field and back (600 feet)

_________________ One lap around a track (1,320 feet)

How far can the applicant walk with assistance? Please check all that applies.

_________________ Length of one football field (300 feet)

_________________ Less than one city block (500 feet)

_________________ One length of a football field and back (600 feet)

_________________ One lap around a track (1,320 feet)

Does the applicant use a mobility device? Please check all that apply.

_____ White Cane _____ Orthopedic Cane (3 or 4 prong)

_____ Walker _____ Brace _____ Crutches

_____ Wheel Chair _____ Motorized Wheel Chair

_____ Scooter _____Other

Part 4 of Part B

Does the applicant have the capability to:

Give address and phone number? _____Yes _____No
Recognize a destination or landmark? _____Yes _____No
Deal with unexpected situation that may occur while in transit? _____Yes _____No
Ask for / understand and follow directions? _____Yes _____No

In your professional opinion does the applicant require a personal care attendant/assistant when traveling by bus?
_____Yes _____No

If yes, Name and phone # _____
_____

Does applicant have any other medical conditions of which HCT should be aware?

_____Yes _____No If yes, please describe: _____
_____

I certify that the information contained here is true and correct to the best of my professional knowledge and ability.

Signature_____ Date_____

Print Name_____

Professional Title_____

Clinic / Agency_____

Phone Number_____ Fax Number _____

Address _____

City _____ State _____ Zip_____