HCT APPLICATION FOR PARA TRANSIT SERVICE ELIGIBILITY

PLEASE READ THE FOLLOWING BEFORE COMPLETING THIS APPLICATION

The City of Hattiesburg and Hub City Transit is committed to providing services that allow those with disabilities to travel on our regular public transportation routes, therefore **ALL FIXED ROUTE BUSES ARE WHEELCHAIR ACCESSIBLE.** Passengers who are unable to ride the Fixed Route Service due to their specific needs are good candidates for Para Transit Service.

Please answer all questions honestly and thoroughly, as the answers will assist in determining the appropriate service to match your abilities. **HAVING A DISBILITY DOES NOT AUTOMATICALLY MAKE SOMEONE ELIGIBILE FOR PARA TRANSIT SERVICE.** Eligibility is determined based on how the disability affects the applicant's ability to travel safely on the Fixed Route service.

All applicants should complete and return **Part A: Section 1 and 2; Part B – Section 1** of the application, completed and signed, to Hub City Transit (please see address at bottom of page). You signature in Part B:1 of the Medical Release Page authorizes your Licensed/Certified Health Care Provider to release specific medical information to our office. On the Medical Release page, please be certain to provide complete information for the Licensed/Certified Health Care Provider who can appropriately answer questions about your specific needs and abilities.

Part B:2 must be completed and signed 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.

The information provided by you and your physician will be treated with integrity and all employees involved will respect your privacy. ***No information will be shared with an outside entity.***

*Please mail **completed** applications to:*

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

OR

Fax to: (601) 545-7507

PART A – Section 1

APPLICANT INFORMATION (please print)

Date submitted: _____/_____/_____

Please check one: New Applicant ❑ Re- Certification Application ❑

Name: _____

First Name MI Last Name

Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____

Primary phone #: _____ Alternate phone #: _____

DOB: _____/_____/_____ Male ❑ **OR** Female ❑ Hispanic ❑ **OR** Non-Hispanic ❑

In case of emergency, contact: _____

Emergency contact phone #: _____

.....

Please check all types of locations for which you would use transit services:

❑ Medical facility	❑ Workplace	❑ Grocery store
❑ Drug Store	❑ Government office	❑ Mall/Retail store
❑ Movie Theater	❑ Salon/Barber shop	❑ Church
❑ Park/Zoo	❑ Restaurant	❑ Gas station

❑ Other (please list): _____

In detail, please describe your limited mobility:_____

_____

_____

_____

_____

What limitations prevent you from riding the regular transit service? _____

_____

_____

_____

PART A - Section 2

Are there any other physical or mental disabilities that may impact your **FUNCTIONAL ABILITY** to ride the regular Fixed Route service? YES ❑ NO ❑

If YES, please explain: _____

_____

_____

Are you able to board the bus without help? YES ❑ NO ❑

If NO, will you have someone to ride with you and assist? YES ❑ NO ❑

* *Information about the attendant who will ride with you:*

Name: _____ Contact #: _____

Which of the following mobility devices will you use while aboard Para Transit?
(Please check ALL that apply)

❑ Manual Wheelchair	❑ Motorized Wheelchair	❑ Power scooter
❑ Motorized upright chair	❑ Visual Aides	❑ Hearing Aides
❑ Walking Cane	❑ Walker	❑ White Cane
❑ Crutches	❑ Portable Oxygen tank	❑ Prosthetic Limb(s)

❑ Service Animal

Please state type of animal and function: _____

❑ TTV or Video phone *Please provide service #:* _____

Approximately 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)

Without assistance, are you able to….

- Walk up 12-14 inch steps? YES ❑ NO ❑
- Grip a handrail to support yourself? YES ❑ NO ❑
- Sit down safely in a seat? YES ❑ NO ❑
- Communicate with the bus driver? YES ❑ NO ❑
- Carry 1 to 4 bags onto the bus? YES ❑ NO ❑

PART B – Section 1

CONSENT TO RELEASE MEDICAL INFORMATION

(to be completed by applicant before submitting to Physician)

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

Licensed Physician or CNP_____

Clinic Affiliation (if applicable): _____

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 **Date**

❑ *Check this box if someone other than the applicant completed this application. (See below)*

*****Representative or Guardian***** *- If you completed and signed this application on behalf of the applicant, please provide the following information about yourself:*

Name of Representative/Guardian: _____

Relationship to Applicant: _____

Address: _____

Home phone: _____ Work phone: _____

Does the applicant reside with you? _____ YES _____NO

Part B – Section 2

Medical / Professional Verification

Applicants Name: ____

Address: ____

Date of Birth: _________________ Social Security #: _______/______/__________

>>>

This Section is to be completed by a Physician or PA ONLY
(Not a request for copies of medical records)

Please describe the applicant's limitations due to their disability or condition:

____
____
____

Is the applicants Disability/ Condition Permanent? _______Yes _______No
If temporary, when will the applicant be able to resume normal activity? (date or time frame)

____
____

Part B – Section 3

Medical / Professional Verification

How far can the applicant walk **without** 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)	Wheel Chair________
Walker ________	Orthopedic Brace _______	Crutches ________
Wheel Chair________	Motor wheelchair ________	Scooter ________

Part B – Section 4

Does the applicant have the capability to:

Verbally share address and phone number?	_____Yes	_____No
Recognize a destination or landmark?	_____Yes	_____No
Deal with an unexpected situation while in transit?	_____Yes	_____No
Verbalize their needs to others?	_____Yes	_____No
Understand and follow directions?	_____Yes	_____No

In your professional opinion does the applicant require a Personal Care Attendant or Assistant when traveling by bus? _____Yes _____No

If you have any other concerns about this applicant in relation to overall passenger safety, please describe those concerns below:

_____

_____

_____

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 /Practice site: _____

Contact number: _____

Fax number: _____

Address: _____

City/State/Zip: _____

PLEASE RETURN THE COMPLETED FORM TO THE FOLLOWING ADDRESS OR FAX:

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

OR

Fax to: (601) 545-7507