HCT APPLICATION FOR:

(Please Check One)

☐ CITIZENS WITH DISABILITIES

☐ PARATRANSIT 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.**

Part A Section 1 & 2 Citizens with Disabilities or Paratransit Service Eligible (**Senior Citizens** or **Passengers who are 61 and under)** who unable to ride the Fixed Route Service due to their specific needs can use the **Paratransit Service** for a fee of fifty cent (.50). **Each applicant should complete the whole application.**

Part B: Section 1 Medical Release Page which 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 and make sure to sign this release.

Part B: Section 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 any outside entity.***

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

Hub City Transit Operations Center
1001 S. Tipton Street
Hattiesburg, MS 39401

OR

Fax to: (601) 545-7507

HUB CITY TRANSIT

PART A – Section 1 DISABLE OR PARATRANSIT

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 #: _____

PART A - Section 2 DISABLE OR PARATRANSIT

In detail, please describe your limited mobility:_____

_____

_____

_____

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 #: _____

PART A - Section 2 (Continue) DISABLE OR PARATRANSIT

Which of the following mobility devices will you use while aboard Paratransit? (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 ☐

PARATRANSIT ONLY

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): _____

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

_____

_____

PART B – Section 1 DISABLE OR PARATRANSIT

CONSENT TO RELEASE MEDICAL INFORMATION

(to be completed by applicant before submitting toPhysician)

(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 ADAParatransit 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 rightto 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

HUB CITY TRANSIT

Part B – Section 2 DISABLE OR PARATRANSIT

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
- ☐ Crutches
- ☐ Walker
- ☐ Orthopedic Cane (3 or 4 prong)
- ☐ Orthopedic Brace
- ☐ Scooter
- ☐ Wheel Chair
- ☐ Electric Wheel Chair

Part B – Section 4 DISABLE OR PARATRANSIT

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 Attendantor 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
1001 S. Tipton Street
Hattiesburg, MS 39401

OR

Fax to: (601) 545-7507