MACON-BIBB COUNTY TRANSIT AUTHORITY
PARATRANSIT DIVISION
APPLICATION FOR PARATRANSIT SERVICE ELIGIBILITY

Thank you for your interest in the MTA Paratransit service. Eligibility for Paratransit service is limited to residents within the Macon-Bibb County Transit Authority's Paratransit service area with a disability that affects their ability to travel. This program does not reflect a disabled person's income or the fact that their disability limits their ability to earn income.

This application must be filled out completely by the applicant and a personal care attendant (if needed), AND by the applicant's licensed or certified healthcare professional, which may include, but is not limited to a licensed physician or nurse, vocational rehabilitation counselor, or social worker. **A signature is required.**

If a question does not apply, please use "N/A" for not applicable.

The information obtained in the certification process is confidential and only will be used by the Macon-Bibb County Transit Authority Paratransit division to determine eligibility for transit services. It will not be provided to any outside person or agency.

If you have any questions regarding the completion of this application, please call June Slaughter, Paratransit Manager, at (478) 803-2521.

***If you are not the applicant, but are completing the application on the applicant's behalf, please print the answer to the following questions.**

Full Name of Person Completing Application _____
Relationship to Applicant _____
Address _____
City _____ County _____
State _____ Zip _____
Primary Phone _____ Secondary Phone _____
Email Address _____
Signature _____

Applicant's Information (to be completed by the applicant)

Last Name _____ First _____ MI ____
Place an X Beside Your Gender ___Male ___ Female Email _____
Work Phone _____ Home or Primary Phone _____
Date of Birth _____ Age_____ Social Security # _____
Street Address _____ Apt. # _____
City _____ County _____
State _____ Zip _____

Mailing Address (if different from permanent residence)

Address _____
City _____County _____
State _____ Zip _____

Are you able to get on and off a bus or van that does not have a passenger lift? _____ Yes _____ No
Are you able to provide your address and phone number upon request? _____ Yes _____ No
Are you able to recognize a destination or landmark? _____ Yes _____ No

Do you use any of the following mobility aids or specialized equipment? Check all that apply.
_____ Cane _____ Power Scooter (3-wheeler) _____ Walker _____ Crutches _____ Leg Braces
_____ Service Animal (if so, type & breed) _____
_____ Power Chair/size of chair? _____ Weight _____

Emergency Contact
Name _____ Relationship _____
Street Address _____ Apt. # _____
City _____ State _____ Zip_____
Cell or Home Phone _____Work Phone _____

I certify that all of the information I have provided in this application is true and accurate. I understand that falsifying my application will result in denial of services.

I understand that all information will be kept confidential and only the information required to provide the services will be disclosed, and only to those who perform the service(s).

I understand that Macon-Bibb County Transit/Paratransit Division will contact my healthcare professional to confirm the information provided in this application.

I authorize my healthcare professional to release any/all information required by Macon-Bibb County Transit/Paratransit Division to determine my eligibility.

Print Full Name _____

Signature _____

Date _____

REQUEST FOR HEALTHCARE PROFESSIONAL VERIFICATION

This Section Must Be Completed by a Licensed/Certified Healthcare Professional

Please complete and sign the form below regarding the applicant's disability/disabilities and its/their impact upon his/her ability to utilize transit services. The information you provide will assist the Macon-Bibb County Transit/Paratransit Division determine whether the applicant is eligible for our services.

To qualify, the applicant must have a disability or disabilities that prevent(s) him/her from using fixed route transit service.

Place an X beside the reason applicant is seeking ADA Paratransit eligibility and check all that apply.

_____ Applicant can use regular fixed route buses to go some places, but not other places.

_____ Applicant has used a fixed route bus previously. _____ Yes _____ No

_____ Applicant can only use a fixed route bus sometimes, and only if equipped with a wheelchair lift.

_____ Applicant can never use a fixed route bus.

What makes it difficult for the applicant to get to or from a fixed route bus stop? Check all that apply.

_____ Lack of curb cuts

_____ Uneven surface

_____ Difficulty recognizing landmarks

_____ Crossing a busy street and/or intersection

_____ Inability to travel at night due to vision problem(s)

_____ Sidewalk or terrain is too steep

_____ Very cold weather, or ice/snow

_____ Very hot weather

_____ Potential to become confused/disoriented

What is the applicant's capability regarding riding on a fixed route bus? Is applicant able to:

Calculate bus fare?	_____ Yes	_____ No
Place bus fare in the fare box?	_____ Yes	_____ No
Cross the street once he/she exits a bus?	_____ Yes	_____ No
Follow instructions in case of an emergency?	_____ Yes	_____ No
Reach his/her destination after exiting a bus?	_____ Yes	_____ No

If applicant answered "No" to any questions above, explain answer(s) and provide full details.

_____

_____

_____

Is applicant able to climb three-11 inch steps and/or find a bus seat independently? ____ Yes ____ No

Is applicant able to get to and from a fixed route bus stop on his/her own, or with the assistance of a mobility aid such as a cane, walker or wheelchair? ____ Yes ____ No

Is applicant able to wait 10-15 minutes at a bus stop? ____ Yes ____ No

Does applicant use a mobility aid? If so, check all that apply.

Wheelchair _____ Manual _____ Motorized Wheelchair size _____
Scooter (i.e. Amigo) ____ Yes ____ No Scooter size _____
_____ Folding/Non-Folding Walker _____ Long White Cane _____ Cane _____ Leg Brace
_____ Service Animal Type/Breed _____

NOTE: The MTA might not be able to accommodate a wheelchair or scooter longer than 48 inches, or wider than 32 inches, or, if applicant's total weight, including wheelchair or scooter, exceeds 1,000 pounds.

Using a mobility aid or independently, how far can the applicant travel?

_____ Cannot travel more than 200 feet.

_____ Able to the curb in front of a house or apartment building.

_____ Able to travel up to 3 blocks (approximately 1/4 mile).

_____ Able to travel up to 6 blocks (approximately 1/2 mile).

_____ Able to travel up to 9 blocks (approximately 3/4 mile).

Will an aide be traveling with the applicant? _____ Yes _____ No

Describe applicant's disability status.

_____ Permanent

_____ Temporary, if so, how long? _____ 3 to 6 months _____ 6 to 9 months _____ 9 to 12 months

Explain HOW the applicant's disability or health-related condition prevents the application from independently using the fixed route transit service.

_____
_____
_____

I certify that _____ who currently resides at _____ is a disabled person due to the following criteria(s).

IDENTIFY ALL APPLICABLE CRITERIA

1. SPECIFY NON-AMBULATORY DISABILITY/DISABILITIES

Impairments that, regardless of cause or manifestation, for all practical purposes confines this individual to a wheelchair. _____

_____

2. SPECIFY SEMI-AMBULATORY DISABILITY/DISABILITIES

Impairments that cause this individual to walk with difficulty or insecurity. Individuals using braces or crutches, amputees, and those with arthritic, neuromuscular, pulmonary, or cardiac disorders or be semi-ambulatory. _____

_____

3. SPECIFY SIGHT DISABILITY/DISABILITIES

Total blindness or impairment affecting sight to the extent that the individual functioning in public areas is insecure or exposed to danger. _____

_____

4. SPECIFY HEARING DISABILITY/DISABILITIES

Total deafness or uncorrectable hearing handicaps that might make an individual insecure in public areas because he/she is unable to communicate or hear warning signals**.** _____

_____

5. SPECIFY DISABILITY/DISABILITIES RELATED TO COORDINATION

Faulty coordination, palsy from brain, spinal, or perinea nerve injury. _____

_____

6. MENTAL DISORDER(S)

Applicant is unable to perform routine repetitive tasks or has physical or other mental impairment(s) resulting in restriction of function and cannot become licensed to operate a vehicle. _____

_____

7. BRAIN DAMAGE

Diagnosis by a psychiatrist, neurologist, or clinical pathologist establishing that the applicant has an organic brain syndrome. _____

_____

8. OTHER DISABILITY/DISABILITIES NOT LISTED _____

_____

Is the applicant's condition temporary? _____ Yes _____ No
If yes, expected duration is _____ months
Does the applicant require a personal care attendant for travel? _____ Yes _____No
Does applicant use mobility aids? ____Yes ____No
If yes, what type? _____

Healthcare Provider's Name _____
Name of Practice/Company _____
Office Street Address _____
City _____ **State** _____**Zip:** _____
Office Phone _____ **Email** _____
Professional License # _____ **or Certification #** _____

Signature: _____ **Date** _____

Please check the status that best describes you.
_____ **Physician** _____ **Social Worker** _____ **Vocational Rehabilitation Counselor** _____ **Other**
If other, please specify: _____

Thank you for your assistance.

APPLICANT
Please return completed application AND Request for Healthcare Professional Verification:

BY MAIL **Paratransit Division, Macon-Bibb County Transit Authority**
Terminal Station, 200 Cherry Street, Macon, GA 31201
BY FAX **(478) 803-2537**
BY EMAIL **june@mta-mac.com**