



Monroe Transit System Paratransit Eligibility Application

Introduction

The Monroe Transit System (MTS) has updated its Paratransit eligibility application process effective July 10, 2006. The new process includes two parts: a completed application by the applicant and a healthcare professional authorization.

The MTS Paratransit Eligibility Application will be used to determine which MTS service best meets your needs. Some individuals with disabilities will be able to use fixed route transit as a result of new accessible features offered by Monroe Transit fixed route buses:

- All buses are equipped with lifts and an announcement system that identifies major bus stops.
- All buses offer priority seating areas for seniors and persons with disabilities, and two wheelchair positions with seatbelts.
- Many buses offer a kneeler feature making stepping onto the bus easier.

Other persons will require Paratransit services for some or all of their transportation needs. The Paratransit service is a curb-to-curb, shared ride public transportation service for individuals with disabilities who are prevented from using fixed route service due to their disability.

Directions

Application

The first step in the evaluation process is to submit the Paratransit Eligibility Application form (pages 3-8). The applicant must complete the entire evaluation form, including the Healthcare Professional Authorization Release Form.

Be sure to complete every item and sign the release forms. The application must be complete before MTS can proceed with the review process. If any portion of the application or the release forms is not completed, the application will be returned to the applicant.

If you need assistance in completing the application or need the application provided in an alternate format, please call MTS at 329-2506, and we will be happy to assist you. Applications must be mailed to:

Monroe Transit: Paratransit Program
700 Washington Street
Monroe, LA 71201

MTS is not responsible for applications sent to any other address or faxed.

Healthcare Professional Authorization

Once the completed application is received, MTS will mail a Healthcare Professional Certification to the person named on the applicant's authorization form. After the certification form is returned, the application will be reviewed by MTS.

Eligibility Certification

MTS will make a determination as to which transit services the applicant can receive and will notify the applicant within 21 days of the receipt of the Healthcare Professional Authorization.

Privacy Statement

The information obtained by MTS in the application process will only be used by MTS and the Federal Transit Administration for the provision of public transit services. The information will be kept confidential and will not be provided to any other persons or agencies.

**Monroe Transit System
Paratransit Eligibility Application**

Part 1 – General Information

Do you need the application and future written information from MTS provided in an accessible format? Yes _____ No _____

If yes, specify the format you prefer: _____

It is important to complete all parts of this form. Please type or print. Applications that are not fully completed or legible will be returned.

Name: _____
 First Middle Last

Social Security Number: ____ - ____ - ____ Date of Birth: _____

Home Address: _____
 Street Apt #

Home City: _____
 City State Zip

Applicant's Phone: Daytime: _____ Evening: _____

Closest Cross Street(s): _____

Closest Bus Stop(s): _____

Mailing Address (if not home): _____

City: _____ State: _____ Zip: _____

Frequent Destination(s)	Closest Bus Stop(s)
_____	_____
_____	_____
_____	_____

**Monroe Transit System
Paratransit Eligibility Application**

Emergency Contact Name: _____ Relation: _____

Work Phone: _____ Home Phone: _____ Cell: _____

If assistance was provided in filling out this form, please indicate by whom:

Name: _____ Day Phone: _____ Relation: _____

Is this the person to contact if additional information is needed? Yes__ No__

Part 2 – Transit Needs Evaluation

1. Are you able to ride an ADA accessible fixed route bus?
Yes ____ No ____ Sometimes ____ I don't know ____

a. If your answer is not YES, WHAT functional limitation(s) or health-related condition might impede or prevent you from using fixed route transit?

b. Explain HOW your functional limitation(s) or health-related condition might prevent you from using the fixed route transit services.

c. Are the limitations/conditions you described permanent ____ or temporary__?

d. Does your health condition or transportation-related disability change from day to day in a way that affects your ability to use fixed route buses?

Yes ____ No ____ Don't Know ____

If yes or don't know is selected, explain why: _____

2. How do you currently travel to your most frequent destinations? Check all that apply:

Fixed route buses ____ Paratransit ____ Medicaid ____ Taxi ____
Someone drives me ____ Drive myself ____ Other (specify) _____

For questions 3 through 12, please indicate whether you are independently able to perform the following functions. When answering "No" or "Sometimes", an explanation is required or the application will be considered incomplete.

3. Are you able to understand directions needed to complete a trip? (This does not include being unaccustomed to the English language.)

Yes ____ No ____ Sometimes ____ If "No" or "Sometimes", explain:

4. Are you able to identify the correct bus stop?

Yes ____ No ____ Sometimes ____ If "No" or "Sometimes", explain:

5. Are you able to identify the correct public transit vehicle (bus)?

Yes ____ No ____ Sometimes ____ If "No" or "Sometimes", explain:

6. Are you able to get to and from the nearest bus stop?

Yes ___ No ___ Sometimes ___ If "No" or "Sometimes", explain:

7. On a good day, how many city blocks can you travel
without a mobility aid? _____
with a mobility aid? _____

8. Are you able to wait at least 15 minutes at a bus stop?

Yes ___ No ___ Sometimes ___ If "No" or "Sometimes", explain:

Could you wait longer than 15 minutes?

Yes ___ No ___ Sometimes ___ If so, how long? _____ (minutes)

Could you wait if there were a bench of bus shelter?

Yes ___ No ___ Sometimes ___ If "No" or "Sometimes", explain:

9. Are you able to get on or off a bus with a lift or when the bus is lowered?

Yes ___ No ___ Sometimes ___ If "No" or "Sometimes", explain:

10. Are you able to grasp handles or railings, coins or tickets while boarding
or exiting a bus?

Yes ___ No ___ Sometimes ___ If "No" or "Sometimes", explain:

11. Are you able to maintain your balance when seated on the bus?
Yes ___ No ___ Sometimes ___ If "No" or "Sometimes", explain:

12. Have you ever had training or instruction on how to use fixed route bus service? Yes ___ No ___

a. If Yes, what person or agency provided the training? _____

b. If no, do you want or need training? Yes ___ No ___

13. Can you transfer from your wheelchair to a seat in a vehicle?

Yes ___ No ___

14. Do you use any of the following mobility aids or equipment?

<input type="checkbox"/> Cane	<input type="checkbox"/> Power Wheel Chair	<input type="checkbox"/> Communication Board
<input type="checkbox"/> White Cane	<input type="checkbox"/> Large Power Wheel Chair	<input type="checkbox"/> Service Animal
<input type="checkbox"/> Walker	<input type="checkbox"/> Power Scooter (3-wheels)	<input type="checkbox"/> Leg Braces
<input type="checkbox"/> Crutches	<input type="checkbox"/> Manual Wheel Chair	<input type="checkbox"/> Other _____

15. Does a personal care attendant (PCA) accompany you when you travel outside your home (i.e. to push your wheel chair, carry oxygen, etc.)?

Yes ___ No ___ Sometimes ___ If "Yes" or "Sometimes", explain:

16. Do you currently use Paratransit service?

Yes ___ No ___ Sometimes ___

If "Yes" or "Sometimes" is selected, when do you use Paratransit Service?

Please give Paratransit provider's name: _____

Optional Information

The following information may be used to secure funding from other sources

Are you participating in or plan to participate in a WIA (Workforce Investment Act) Training program? Yes ___ No ___

If YES, please give name of your WIA contact and phone number:

Contact Name _____ Phone: _____

Are you participating in or plan to participate in an LRS (Louisiana Rehabilitation Service), Veterans Administration or Federal Vocational Rehabilitation training program? Yes ___ No ___

If YES, please give name of your counselor and phone number:

Counselor Name _____ Phone: _____

Do you currently use Medicaid? Yes ___ No ___

What are you primary transportation needs? Please check all that apply.

Work	_____	Medical Appointments	_____
Banking/Legal	_____	Shopping	_____
Education	_____	Entertainment	_____
Day Care	_____	Address	_____
Dialysis	_____	Address	_____

Applicant Certification (REQUIRED)

I certify that the information in this application is true and correct. I understand that falsification of the information may result in denial of some MTS services and/or discounts. I understand all information will be kept confidential, and only the information required to provide the services for which I am eligible will be disclosed to those who perform the services. I understand that it may be necessary to contact a licensed/certified healthcare or allied health professional familiar with my functional abilities/health related conditions in order to assist in an accurate application review. I also acknowledge that I have received the MTS Paratransit Ride Guide and agree to comply with all rules and regulations of MTS.

Applicants signature _____ Date: _____

Signature of person assisting in completing application _____

Date: _____



Monroe Transit System

Healthcare Professional Authorization Release Form

I hereby authorize _____
(Print name of licensed physician, licensed nurse practitioner, or state licensed or nationally certified allied health/rehabilitation professional familiar with your transit related limitations or health related condition)

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

to release to Monroe Transit System necessary information about my functional limitation(s) and/or health related condition that affect my ability to use public transit. This information combined with my application will be used to determine the type(s) of public transportation I am eligible for.

- All released information will be kept confidential and used only on a need to know basis.
- I have the right to receive a copy of this authorization.
- I understand that I may revoke this authorization at any time.

Name of applicant (print)

Date Signed

Applicant's Signature