

PARATRANSIT ELIGIBILITY APPLICATION

Field Trips Assist provides services to individuals who cannot use the regular Field Trips system to make all of their trips.

Part 1 must be filled out with the applicant's answers. The applicant can receive assistance from another person but wherever possible the applicant's answers must be written. If another person assists please state their relationship at the end of Part 1 and have the applicant sign. **Part 2 must be filled out by your healthcare professional** verifying your answers to be true according to your medical records and giving permission to release any information needed to make our determination.

PLEASE TYPE OR PRINT CLEARLY IN INK

Last Name:_____ First Name:_____ MI:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home #:_____ Work # _____ DOB: _____

E-mail Address:_____

If you use an aid, check those that apply:

- | | | |
|--|---|--|
| ☐ Manual wheelchair | ☐ Crutches | ☐ Portable oxygen |
| ☐ Electric wheelchair | ☐ Walker | ☐ Walking cane |
| ☐ 3-wheel scooter | ☐ Service Animal | ☐ Cane used by the
visually impaired |

Do you have any of the below disabilities?

- | | |
|--|--|
| ☐ Brain injury | ☐ Deaf/blind |
| ☐ Speech impediment | ☐ Mental health condition |
| ☐ Visually impaired | ☐ Hearing aid |

Do you travel with a Person Care Attendant (PCA)?

- ☐ Yes
- ☐ No

PART 2

TO BE COMPLETED BY HEALTHCARE PROFESSIONAL

RELEASE OF INFORMATION/CONSENT FORM

In order to allow the the TCC Transportation Planner to evaluate your request, it may be necessary to contact your physician or some other healthcare professional that is familiar with your disability to confirm the information you have provided. Please complete the following questions and authorization form.

Please provide proof this form has been completed by a Physician or Healthcare Professional (i.e., stamp, etc.)

____ Physician ____ Healthcare Professional ____ Rehabilitation Professional

Other _____

After checking above, please list your name, title, occupation, address, phone & signature

Name	Title	Occupation
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Address	City, State, Zip Code
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X _____

Signature of Physician or Healthcare Professional

Address	City, State, Zip Code
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I authorize the professional(s) named above to release any information necessary to the TCC Transportation Planner.

Applicant's Signature: _____ Date: _____

Witness (Other than the Assistant General Manager):

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If someone other than the applicant requesting certification has completed this application in whole or in part, that person must complete the following. A COPY OF THE POWER OF ATTORNEY FORM MUST ALSO ACCOMPANY THIS PACKET.

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ DOB: ____/____/____

TELEPHONE NUMBER [Home] () _____ [Work]() _____

RELATIONSHIP: _____

SIGNATURE: _____ DATE: _____

REQUEST FOR CERTIFICATION OF FIELD TRIPS ASSIST ELIGIBILITY

Please identify a relative or close friend who we may contact in the event of an emergency. (Please print clearly and complete all information asked)

NAME:_____

ADDRESS:_____

CITY:

_____ STATE _____ ZIP:_____ DOB: ____/____/____)_____

RELATIONSHIP_____

TELEPHONE NUMBER

.....
(TO BE USED FOR CERTIFICATION PURPOSES ONLY)

I hereby certify that the individual's name which appears on this REQUEST FOR CERTIFICATION OF ADA PARATRANSIT ELIGIBILITY form

Has_____/has Not _____been approved.

Month/Year for Annual Re-Certification: ____/____

Month/Year for Temporary Re-Certification:____/____