**Field Trips c/o TCC**
3130 East Main Str. Suite 2a
Springfield, Ohio 45505

# 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

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Last Name:_____ First Name:_____MI:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home #:_____Work #_____DOB:_____

E-mail Address:_____

Please check all the following media you currently use:

☐ Large Print AutoCassette Braille Electronic (E-mail)

**1. What type of condition(s) prevents you from using Field Trips? (Check all that apply)**

☐ None ☐ Physical ☐ Visual ☐ Deaf / Blind

☐ Brain Injury ☐ Speech ☐ Hearing ☐ Mental Health Condition

☐ Mental Retardation / Developmentally Delayed

☐ Other (Current Diagnosis): _____

_____

**2. Is this condition Temporary?** ☐ Yes ☐ No

**If Yes, what is the expected duration?** _____ **Months**

**3. Do you currently use the Field Trips Microtransit system?**

☐ Yes ☐ Sometimes ☐ No

**4. Are you able to get on and off a Field Trips Wheelchair Accessible Vehicle without assistance? (The driver will secure the wheelchair / scooter).**

☐ Yes ☐ Sometimes ☐ No

**If you cannot, please explain:** _____

_____

**5. Are you able to do the following functions independently?**

| | YES | SOMETIMES | NO |
|---|---|---|---|
| Find your way between familiar locations? | | | |
| Grasp handles? | | | |
| Communicate address, destinations, and telephone numbers on request? | | | |
| Ask for, understand, and follow directions? | | | |
| Deal with unexpected situations or unexpected changes in routine? | | | |
| Able to go up and down steps? | | | |
| Recognize a destination or landmark? | | | |
| Walk or use a wheelchair / scooter 200 feet? (city block) | | | |
| Walk or use a wheelchair and travel ¼ mile (1,300 feet / just under 4 ½ football fields)? | | | |

**6. 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** |

**If you use a manual or powered wheelchair or scooter, when in use, does the device meet the following criteria:**

| | YES | NO |
|---|---|---|
| Ramp Width: 32.25 inches of usable clear opening | | |
| Ramp Length: 45 inches | | |
| Ramp Capacity: 1,000 lbs (Rider + Wheelchair) | | |
| Entrance Height: 56 inches | | |

**7. Do you need a person to assist you when you are traveling?** ☐ **Yes** ☐ **No**

**If you travel with another person that assists you, does this person assist you in:**

☐ **Getting you where you are going** ☐ **Getting on or off the vehicle**

☐ **Assist you once you get to the destination**

☐ **Other (Please Explain):** _____

_____

# PART 2
# TO BE COMPLETED BY HEALTHCARE PROFESSIONAL

**RELEASE OFINFORMATION/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**

_____

**Address City, State, Zip Code**

**X** _____

**Signature of Physician or Healthcare Professional**

_____

**Address City, State, Zip Code**

**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 ELIGIBILTY

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 ELIGIBILTY form

Has_____/has Not _____been approved.

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

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