Field Trips c/o TCC
3130 East Main Str. Suite 2a
Springfield, Ohio 45505
Or submit form through the Field Trips Website or email to gmassie@clarkcountyohio.gov

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, checkthose that apply:

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

Do you have any of the below disabilities?

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

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

- ☐ Yes
- ☐ No

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):

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:_____/_____