ADA COMPLEMENTARY PARATRANSIT ELIGIBILITY APPLICATION

APPLICANT INFORMATION

Last Name | First Name | MI | Date of Birth

Phone Number | Cell ☐ | Home ☐ | Phone Number | Cell ☐ | Home ☐

email | Sex ☐ M ☐ F | Language

Street Address | Apartment # | Building #

City | State | Zip Code | Require gate code? ☐ Y ☐ N | Code:

EMERGENCY CONTACT INFORMATION *(optional)*

Last Name | First Name

Phone Number | Cell ☐ | Home ☐ | Relationship

NON-APPLICANT COMPLETING THE APPLICATION (*If you are completing this application for someone else please provide your information)* ***IF CLIENT IS UNABLE TO SIGN, THE SIGNATURE OF THE INDIVIDUAL COMPLETING THE APPLICATION IS REQUIRED BELOW**

Last Name | First Name

Phone Number | Cell ☐ | Home ☐ | Relationship

I authorize my health care professional to release any and all information about my disability or health condition and its affect on my ability to travel on the Fixed Route Bus. I understand that I may revoke this authorization at any time. I understand that the Mobility Coordinator's office may contact the health care professional who completed the verification attached to this application, in order to confirm this information. I understand that all medical information will be kept strictly confidential. I hereby certify that, to the best of my knowledge, information given in this application is correct. I understand that intentionally providing false or misleading information may affect my eligibility for ADA complementary paratransit. I agree to notify the Mobility Coordinator's office if my condition changes, if I am using a new mobility device, or if I no longer need to use ADA complementary paratransit services.

Signature | *Date*