



**This page is to be completed by APPLICANT**

**Part 1: Questions about your Disability**

**1. Please choose what type or types of disabilities prevent your from using our fixed bus route (check all that apply).**

- Physical Disability     Dialysis Patient     Development Disability  
 Mental Disability     Other \_\_\_\_\_     Visual Impairment/Blindness

**Please describe your disability in more detail:**

\_\_\_\_\_

**2. Please explain how your disability prevents you from utilizing our fixed route bus service?**

\_\_\_\_\_

**3. Please indicate the use of any of the following mobility aids or equipment. (Check all that apply.)**

- Cane                       White Cane (for blindness)                       Powered Scooter/Cart  
 Walker                       Manuel Wheelchair                       Portable Oxygen/Respirator  
 Crutches                       Communication Aid                       Service/Guide Animal: describe \_\_\_\_\_  
 Prosthetic device                       Leg Braces                       I do not use any of the above aids  
 Other: \_\_\_\_\_

If you selected Wheelchair or Scooter, would you prefer/need to use the device while riding LCTS Para-Transit Vehicle?     Yes     No     Sometimes

**4. If you use a wheelchair or scooter:**

- Is it more than 30 inches wide?     Yes     No  
Is it more than 48 inches long?     Yes     No  
Is the combined weight of device and occupant more than 600 pounds?     Yes     No

**5. Do you need to travel with someone who will assist you with your trip?**

- Yes     No     Sometimes

If “yes” or “sometimes”, does a  Personal Care Attendant (PCA) and/or  Companion travel with you on scheduled trips?

**Please fill out question 5a on your Personal Care Attendant (PCA) or Companion that travels with you most frequently.**

**5a. Contact information on Personal Care Attendant (PCA)/Companion**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Agency (if available): \_\_\_\_\_

**Part 2: Questions about using Regular Fixed Routes.**

**1. Have you ever used the fixed routes buses?**

- Yes, I typically use fixed route buses \_\_\_\_\_ times a week
- Yes, I used to but stopped because \_\_\_\_\_
- No

**2. Do you now independently use regular-route city buses?**

- Yes    No    Sometimes

If "Yes" or "Sometimes", how many times? \_\_\_\_\_ per week \_\_\_\_\_ per month \_\_\_\_\_ per year

**3 Which of the following best describes how you use regular-route city buses?**

- To Travel to and from one destination only                       To Travel to and from a few destinations
- To Travel to and from many different destinations             I currently do not use the regular city buses

**4. If you are able to get to and from the bus, can you board the bus by yourself? (Keep in mind that the only assistance offered by the driver is operating the wheelchair lift).**

- Yes    No    Sometimes    I don't know, I have never tried.

**If no or sometimes, please check all that apply:**

- I cannot climb stairs
- I need assistance other than what the driver provides
- I do not want to use the lift

**5. How far from your home is the nearest public bus stop?**

- Less than one (1) block             Five (5) or more blocks
- One (1) - Two (2) blocks         Three (3) - Four (4) blocks
- I don't know

**6. How far can you travel on your own or when using a mobility aid?**

- I can get to the curb in front of my house/Apartment     I can travel up to three 3 blocks (1/4 mile)
- I can travel up to six 6 blocks (1/2 mile)                       I can travel up to nine 9 blocks (3/4 mile)

**7. I can wait for a regular-route city bus (check all that apply):**

- Only if there is a bench or shelter
- Up to fifteen (15) minutes
- More than fifteen (15) minutes

**8. Please check all the categories below as they relate to your ability to use regular-route city buses:**

I am

- A. Able to tolerate very hot or very cold weather
- B. Able to recognize destinations, bus stops, or landmarks
- C. Able to tolerate air pollutions (smog, fumes, perfume)
- D. Able to recognize printed information
- E. Able to hear and process spoken words or auditory information
- F. Able to communicate needs
- G. Able to follow directions
- H. Able to deal with unexpected situations or changes in routes

	Yes	No	Sometimes
A. Able to tolerate very hot or very cold weather			
B. Able to recognize destinations, bus stops, or landmarks			
C. Able to tolerate air pollutions (smog, fumes, perfume)			
D. Able to recognize printed information			
E. Able to hear and process spoken words or auditory information			
F. Able to communicate needs			
G. Able to follow directions			
H. Able to deal with unexpected situations or changes in routes			



**The following must be completed and signed by your current PRIMARY PHYSICIAN.**

**Part 2: Health Care Professional Verification**

The individual who has asked you to review and sign this application is applying to the LCTS Para-Transit System to be considered eligible for the service. ADA Para-Transit service is intended **ONLY** for those trips that the person cannot take on the regular public bus system due to his/her disability.

*Please note that all regular public buses are equipped with wheelchair lifts.*

**1. Name of Physician or Health Care Professional Completing Form:**

Office Address: \_\_\_\_\_

Office Phone # \_\_\_\_\_

Capacity in which you know the applicant: \_\_\_\_\_

**2. What disability prevents the applicant from riding the regular public bus system?**

Physical    Developmental    Cognitive    Visual Disability    Other: \_\_\_\_\_

**3. If the disability is cognitive or developmental, please supply information regarding the applicant's functional abilities. All information will be kept confidential.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**4. Is this condition:**    Temporary    Permanent

If temporary, what is the expected duration? \_\_\_\_\_

**5. Do temperature extremes affect the individual?** (Ex: Heat index of more than 85 degrees or wind chill less than 10 degrees)

Yes    No

**6. Does the applicant require the assistance of a Personal Care Attendant (PCA)?**

Yes    No    Sometimes

If yes, do they need help getting:

- To or from curb in front of residence
- To destination (someone must accompany him/her to ensure safe arrival).
- Upon arrival at destination (may get lost without someone to direct him/her).

**7. Does the applicant currently use a Personal Care Attendant (PCA)?**

Yes    No

**8. Please list all medications.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**9. Is this individual compliant with taking medications?**

- Yes    No

**10. If the applicant has a disability affecting mobility, answer the following:**

Assuming the length of a city block is 500 feet, how many blocks can this person walk without assistance?

- 0-3 Blocks    4-6 Blocks    7-9 Blocks

**11. If using a Mobility aid(s), how many blocks can that applicant travel independently?**

- 0-3 Blocks    4-6 Blocks    7-9 Blocks

**12. Please describe any other functional limitation(s) affecting mobility. Be Specific:**

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**13. Is this person able to:**

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| A. Give his/her address and telephone number on request?                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| B. Recognize landmarks while riding in a moving vehicle?                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| C. Deal with unexpected situations or unexpected changes in routine?    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| D. Ask for, understand and follow directions?                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| E. Safely/effectively travel through complex and/or crowded facilities? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**Please complete only those sections that apply to this individual.**

**Neurological Impairments/Head Injury**

**1. Does the individual experience seizures?**

- Yes    No

If yes, what is the last date of seizure? \_\_\_\_\_

**2. What type(s) of seizures does the patient experience? \_\_\_\_\_**

**3. Does the individual experience auras?**

- Yes    No

**4. Is the individual's judgment impaired?**

- Yes    No

**5. Is behavioral inhibition impaired?**

- Yes    No

**6. Does judgment and inhibition impairment prevent the individual from independently traveling outside the home or immediate environment?**

- Yes    No

**7. When traveling independently does the individual have the ability to:**

- |   |   |
|---|---|
| <input type="checkbox"/> Get help if lost                                   | <input type="checkbox"/> Cross Streets Safely |
| <input type="checkbox"/> Follow written directions                          | <input type="checkbox"/> Communicate Needs    |
| <input type="checkbox"/> Recognize & avoid danger                           | <input type="checkbox"/> Process Information  |
| <input type="checkbox"/> Understand & Follow schedule to get places on time |   |

## Visual Impairments

**1. What type of visual impairment does the applicant have? (Check all that apply)**

- Glaucoma     Night Blindness     Cortical Blindness  
 Cataracts     Legally Blind     Macular Degeneration  
 Retinopathy     Totally Blind     Retinal Detachment

**2. Does the individual require any accommodations, adaptations, or low vision aids, etc? (Please List)**

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**3. How does the individual's visual impairment affect their ability to move about in the environment?**

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## Emotional/Behavior Issues

**1. Does the individual experience any of the following?**

- Auditory Hallucinations     Visual Hallucinations     Delusions     Disassociation

**2. Does this prevent the individual from being oriented to person, place, and/or time?**

- Yes     No

**3. Is the individual currently being treated for any of the following?**

- Anxiety     Depression     Panic Attacks     Schizophrenia     Other: \_\_\_\_\_

**4. For Anxiety panic attacks please indicate on average the frequency and length of panic attacks.**

- Per day \_\_\_\_\_     Per week \_\_\_\_\_     Per month \_\_\_\_\_     Per year \_\_\_\_\_  
 Approx. Duration: \_\_\_\_\_

**5. What technique(s) and/or skills is the individual utilizing to assist in coping with the above issue(s)? (Check all that apply)**

- Visualization     Relaxation Techniques     Positive self-talk     Aroma Therapy  
 Other: (be specific) \_\_\_\_\_

**6. Are these techniques effective in reducing symptoms?**

- Yes     No     Sometimes

## Cognitive/Mental Impairments

**1. Please describe the functional limitations caused by this impairment?**

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**2. Is the individual's judgment impaired?**

- Yes     No

If yes, please describe to what extent or give an example.

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**To the best of your knowledge, the information provided by the Applicant on this form is correct.**

Yes    No

If no, please explain:

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**Failure to complete any section of this application will delay the eligibility determination process.**

**We do not accept applications by fax.  
We only accept original copies of the Application.**

**Professional Verification**

I understand that the purpose of this application is to determine if the applicant is eligible to use the LCTS Para-Transit Services. I certify that the information provided in this application is true and correct. I understand the falsification of this information may result in denial of service to the applicant. I understand that all information will be kept confidential.

Physician Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Date: \_\_\_\_\_ Organization: \_\_\_\_\_