Only original applications Are accepted. No faxed copies allowed

LAKE CHARLES TRANSIT SYSTEM (LCTS) APPLICATION

FOR PARA-TRANSIT SERVICE PROGRAM

LAKE CHARLES TRANSIT SYSTEM (LCTS)
1155 RYAN STREET
LAKE CHARLES, LA 70601
OFFICE (337) 491-1267
FAX (337) 491-1335

If you have physical difficulties that prevent you from effectively using regular Fixed Route Services (within city limits) for trips such as medical or other trips, you may be eligible for the Para-Transit Service Program.
Please answer the questions below in order to enable us to assist you with your transportation needs.

Complete all parts of the form.

Forms that are not fully completed will be returned, which will delay your eligibility determination process.

(Please print or type)

Name: _____
Last First Middle Initial

Street Address: _____ Apt #_____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Cell Phone: (____) _____

In case of an Emergency, who may we contact?

Name: _____ Relationship to you: _____

Street Address: _____ Apt #_____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Cell Phone: (____) _____

If this application is being filled out by someone other than the person requesting certification, please complete the following:

Name: _____ Telephone Number: _____

Relationship to the Applicant: _____

Signature: _____

Office Use Only

*Pending_____ Date: _____ By: _____

_____Approved Date: _____ By: _____

_____Denied Date: _____ By: _____

_____Renewal Date: _____ By: _____

ID # _____ Date Received: _____ Date Issued: _____ Expiration Date: _____

Eligibility Category: _____ P.C.A.: _____ Mobility Device: _____

This page is to be completed by APPLICANT.

Part 1: Questions about your disability

1. **Please explain why you can not use the fixed route service because of your disability. DO NOT LIST ANY MEDICINES.**

_____

_____

_____

_____

_____

2. **Please indicate the use of any of the following mobility aids or equipment. (Check all that apply.)**
   - □ Cane
   - □ Crutches
   - □ Leg Braces
   - □ Manuel Wheelchair
   - □ Portable Oxygen/Respirator
   - □ Powered Scooter/Cart
   - □ Prosthetic Device
   - □ Walker
   - □ White Cane (vision impaired)
   - □ Service Animal (describe) _____
   - □ Other: _____

If you selected wheelchair or scooter, would you prefer/need to use the device while riding LCTS Para-Transit Vehicle?

- □ **Yes**
- □ **No**

3. **If you use a wheelchair or scooter:**
   - Is it more than 30 inches wide and 48 inches long?
     □**Yes**
     □ **No**
   - Is the combined weight of device and occupant more than 600 pounds?
     □**Yes**
     □ **No**

4. **Do you need to travel with someone who will assist you with your trip?**
     □ **Yes**
     □ **No**
     □ **Sometimes**

If **"yes"** or **"sometimes",** will one of the following travel with you on scheduled trip?

     □ **Personal Care Attendant (P.C.A.)**
     □ **Companion**

Please fill out question 4a on your Personal Care Attendant (P.C.A.) or Companion that travels with you <u>most</u> frequently. If you have a P.C.A., <u>please attach written proof from the agency</u>.

4a. Contact information on Personal Care Attendant (P.C.A.)/Companion

Name: _____

Address: _____

Telephone Number: _____

Agency (if available): _____

5. **If you are able to get to and from the bus, can you board the bus by yourself?**

    □ **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

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

    □ I can travel up to two (2) blocks
    □ 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. **Please check all the categories below as they relate to your ability to use regular-route city buses:**

I am:	**Yes**	**No**	**Sometimes**
A. Able to recognize destinations, bus stops or landmarks			
B. Able to recognize printed information			
C. Able to hear and process spoken words or auditory information			
D. Able to communicate needs			
E. Able to follow directions			
F. Able to deal with unexpected situations or changes in routes			
G. Able to recognize curbs and other drop-offs			
H. Able to travel independently along sidewalks			
I. Able to identify the vehicle			
J. Able to get on and off a bus using the ramp if necessary			
K. Able to understand directions needed to complete a trip			
L. Able to wait standing fifteen (15) minutes at a stop			
M. Get on/off the bus without any assistance			

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

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Important Notification to Applicants:

I. **Appointments are scheduled on the hour and half hour only to prevent having conflicts with other passengers.**
II. **Appointments are first come/first serve with origin-to-destination service.**
III. **Passengers have scheduled their own appointments and are aware of their pick-up time. It is your responsibility to be available.**
IV. **Our recommendation is to be ready at least 10 minutes ahead of your pick-up time and be watching. Hold time will end 10 minutes after the scheduled pick-up time.**
V. **All passengers are scheduled based on information provided to our office with appointments we have open. We try very hard to schedule as conveniently as possible for you but we must maintain a scheduled run.**
VI. **If a passenger is not ready for their transportation they scheduled, we will be unable to make a 2nd call based on previously scheduled trips. We can not allow one (1) passenger to make other passengers late for their scheduled appointments.**
VII. **Passengers that are no shows and repeat offenders will cause their service to be reevaluated.**

Applicant's Signature

I certify that the information on this application is true and correct, and I understand that giving false or misleading information may result in denial of LCTS ADA Para-Transit Services. I understand that all information will be confidential to the extent possible, and used to determine my eligibility for LCTS Para-Transit Services.

Applicant's Signature: _____
Date: _____

If unable to sign, please see below.

NOTE: If only able to make a "mark" for your signature, simply make your mark and then have someone act as a witness, preferably, the person who filled out the application for you, by signing their name above or beside yours.

The City of Lake Charles fully complies with Title VI of the Civil Rights Act of 1964, Americans with Disabilities Act, and related statutes, executive orders, and regulations in all programs and activities. The City operates without regard to race, color, national origin, income, gender, age, and disability. Any person who believes him/herself or any specific class of persons, to be subjected to discrimination prohibited by Title VI/Americans with Disabilities Act may by him/herself or by representative file a written complaint with the City of Lake Charles. The City's Title VI Coordinator/ADA Coordinator may be reached by phone at (337) 491-1440, the Mayor's Action Line at (337) 491-1346, or contact the appropriate Department Head.

PHYSICIAN STATEMENT

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

Part 2: Health Care Professional Verification

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

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

Name of Physician or Health Care Professional Completing Form:

Office Address: _____

Office Phone Number: _____

1. **Please explain why this patient can not use the fixed route service because of their disability.**
   DO NOT LIST ANY MEDICINES.

_____

_____

_____

_____

_____

_____

_____

2. **Please describe the mobility limitations of this patient?**

_____

_____

_____

_____

3. **This condition is:**
   - □ Temporary
   - □ Permanent

   If temporary, what is the expected duration? _____

4. **Does the applicant require the assistance of a Personal Care Attendant (P.C.A.)?**
   - □ **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)

5. **Does the applicant currently use a Personal Care Attendant (P.C.A.)?**

□ **Yes**

□ **No**

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

□ I can travel up to two (2) blocks

□ 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. **Please describe any other functional limitation(s) <u>affecting mobility</u>.**

_____

_____

_____

_____

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

Please check Yes or No	**YES**	**NO**
A. Give his/her address and telephone number on request?		
B. Recognize landmarks while riding in a moving vehicle?		
C. Deal with unexpected situations or unexpected changes in routine?		
D. Ask for, understand and follow directions?		
E. Safely/effectively travel through complex and/or crowded facilities?		

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. **Does judgment and inhibition impairment prevent the individual from independently traveling outside the home or immediate environment?**
   - □ **Yes**
   - □ **No**

3. **When traveling independently does the individual have the ability to:**
   - □ Get help if lost
   - □ Follow written directions
   - □ Recognize & avoid danger
   - □ Cross Streets Safely
   - □ Communicate Needs
   - □ Process Information
   - □ Understand & Follow schedule to get places on time

Visual Impairments

1. **What type of visual impairment does the applicant have?**

   _____

   _____

   _____

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

   _____

   _____

   _____

   _____

3. **Please describe the mobility limitations of this patient?**

   _____

   _____

   _____

   _____

4. **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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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: _____

Mailing Address:
Lake Charles Transit
1155 Ryan Street
Lake Charles, LA 70601

Telecommunications Relay Services

The Americans with Disabilities Act (ADA) of 1990 took full effect on July 26, 1993. Title VI of the ADA requires all telephone companies across the United States to provide telecommunications relay services.

A telecommunications relay services (TRS) allows people who are deaf, hard of hearing, or speech impaired to communicate through a communications assistant (CA) with people who use a standard telephone. A CA relays the TTY (text telephone or telecommunications device for deaf and hard of hearing people) input to the telephone user and types that person's response back to the TTY user. Telecommunications relay services can be reached by dialing 711.

Just as you can dial 411 for information, you can dial 711 to access all telecommunications relay services anywhere in the United States. They relay service is free.

CAs are trained to be as unobtrusive as possible during a call. A CAs responsibility is to relay the conversation exactly as it is received. All relay calls are confidential.

Regardless of which long-distance company or organization is providing a state's relay service, callers

can continue to use the long-distance company of their choice.

Two options when using a telephone relay service are voice carry-over (VCO) and hearing carry-over (HCO). VCO allows a person with a hearing impairment to speak directly to the other party and then read the response typed by a CA. HCO allows a person with a speech impairment to hear the other party and relay the TTY response back to the telephone user through the CA. This service allows individuals with communication disorders to communicate with all telephone users.

For more information on telecommunications relay services, please visit the Federal Communications Commission at www.fcc.gov/cgb/dro/trs.html.

NIH Publication No. 94-3754

Nicholas Hunter
Mayor

Department of Public Works
Transit Division

1155 Ryan Street •P.O. Box 900
Lake Charles, LA. 70601
Business: (337) 491-1253
Fax: (337) 491-1335

City of Lake Charles
Para Transit Appeals Form

Please describe the alleged issue that is to be appealed.

Appeals for denials, no shows, and cancellations may be filed with the Transit Department in writing for further review. The appeals process is reviewed by the following board:

- ❖ Transit Manager
- ❖ Assistant Director
- ❖ Director of Public Works/Designated Representative
- ❖ Office of Community Affairs

Appeals will be processed within 21 days from receipt in the Transit Department. After the review process is completed a letter will be mailed to the individual with the decision. Until the appeal process is completed, service will continue for the individual. Service interruption will only occur after the Appeals process is completed and the individual has been notified by mail.

Appellant's Name _____ Appellant's Signature _____

Date Received	Date of Meeting	Date of Ruling	Date of notification

THE CITY OF LAKE CHARLES FULLY COMPLIES WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 AND RELATED STATUTES, EXECUTIVE ORDERS, AND REGULATIONS IN ALL PROGRAMS AND ACTIVITIES. THE CITY OPERATES WITHOUT REGARD TO RACE, COLOR, NATIONAL ORIGIN, INCOME, GENDER, AGE, AND DISABILITY. ANY PERSON WHO BELIEVES HIM/HERSELF OR ANY SPECIFIC CLASS OF PERSONS, TO BE SUBJECTED TO DISCRIMINATION PROHIBITED BY TITLE VI MAY BY HIM/HERSELF OR BY REPRESENTATIVE FILE A WRITTEN COMPLAINT WITH THE CITY OF LAKE CHARLES. THE CITY'S TITLE VI COORDINATOR MAY BE REACHED BY PHONE AT (337) 491-1440, THE MAYOR'S ACTION LINE AT (337) 491-1346, OR CONTACT THE APPROPRIATE DEPARTMENT HEAD.