PARIS METRO
PARATRANSIT APPLICATION

Complete this form and return it to: **Ark-Tex Council of Governments**
240 10th SE Bldg. 5, Paris, TX 75461
903-739-2444
EMAIL to: slong@atcog.org

THE BOTTOM PORTION OF THIS FORM MUST BE FILLED OUT BY A MEDICAL PROFESSIONAL

NAME (Last, First, Middle Initial	Phone No. (Include Area Code) Home: Cell:	Date of Birth
Street Address, City, State, Zip Code		
Do you require a Personal Care Attendant? ☐ YES ☐ NO	Do you use a wheelchair? ☐ YES ☐ NO Scooter ☐ YES ☐ NO ☐ Manual ☐ Electric	
If visually impaired, do you use a guide dog? ☐ YES ☐ NO	Do you use a cane? ☐ YES ☐ NO	Do you use a walker? ☐ YES ☐ NO
Person to notify in case of emergency Name_____ Phone No. _____		
Applicant Signature:		Date:
If application is being completed by someone other than the applicant, please complete the line below. Name:		Relationship:

******THE SECTION BELOW MUST BE COMPLETED BY MEDICAL PROFESSIONAL******

Disability/Medical Diagnosis (Define WHY applicant cannot ride the fixed route bus system in detail)		
Does the client require a Personal Care Attendant? ☐ YES ☐ NO	Combined Weight of Client & Wheelchair: _____ pounds Wheelchair	This is a(n): ☐ Standard Wheelchair ☐ Oversized

Medical Professional Phone	Facility Name	Verifying Professional Name (Print)	Verifying Professional Signature

FOR PARIS METRO OFFICE USE ONLY

Authorized by & Date	☐ APPROVED ☐ New ☐ Recertification ☐ DENIED (If checked, complete next line)
Please state reason for denial	

ANY APPLICANT WHO IS DENIED ELIGIBILITY ARE GIVEN UP TO 60 DAYS TO APPEAL THE DECISION IN WRITING