

PARIS METRO PARATRANSIT APPLICATION

Complete this form and return it to: Ark-Tex Council of Governments
240 10th SE Bldg. 5, Paris, TX 75461

844-437-7497 or 903-739-2444 EMAIL to: srecord@atcog.org

The bottom part of this form MUST be completed by a Medical Professional

NAME (Last, First, Middle Initial)		Phone # Home:		Date of Birth
		Cell:		
Street Address, City, State, Zip Code				
Personal Care Attendant Needed? YES <input type="checkbox"/> NO <input type="checkbox"/>		Do you use a wheelchair? <input type="checkbox"/> YES <input type="checkbox"/> NO Manual <input type="checkbox"/> Electric <input type="checkbox"/> Scooter <input type="checkbox"/> YES <input type="checkbox"/> NO		
Do you use a guide dog? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you use a cane? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you use a walker? <input type="checkbox"/> YES <input type="checkbox"/> 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 sign here				
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)				
Is a Personal Care Attendant required? <input type="checkbox"/> YES <input type="checkbox"/> NO		Weight of Client & Wheelchair: <input type="checkbox"/> Standard <input type="checkbox"/> Oversized _____ pounds		
Medical Prof #	Facility Name	Verifying Professional Name	Verifying Prof Signature	
FOR PARIS METRO OFFICE USE ONLY				
Authorized by & Date		<input type="checkbox"/> APPROVED <input type="checkbox"/> New <input type="checkbox"/> Recertification <input type="checkbox"/> 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**