ATCOG Transportation

Paratransit Application

Please Mail or drop off completed application to: 1610 Clarksville St Paris TX 75460
You may also email this application to: srecord@atcog.org To schedule a ride, call 844-437-7497

****THIS SECTION TO BE COMPLETED BY APPLICANT****			
Name (Last, First, Middle Initial)	Home Phone # Cell Phone #		Date of Birth
Street Address			APT#
City	State	Zip Code	County
Mailing Address (if different)			
Email Address (optional)			

Briefly describe the disability or health condition that prevents you from using the FIXED ROUTE Bus service. (Please list ALL disabilities or health conditions that apply.) FIXED ROUTE means the buses operate on a set routes as determined by ATCOG.

If this is a temporary disability or health condition, how long do you expect it to prevent you from using the FIXED ROUTE Bus service? ________________ **Months**

Do you use any of these Mobility Aids or Equipment? (Check ALL that apply.)

❑ Cane	❑ Powered Wheelchair (Weight: ________Lbs.)
❑ Crutches	❑ Powered Scooter (Weight: _________ Lbs.)
❑ Walker	❑ Manual Wheelchair (Weight: _______Lbs.)
❑ Leg brace	❑ Service Animal
❑ Cane	❑ Portable Oxygen
❑ Prosthesis	❑ Other (please specify) __________________________________

PLEASE BE AWARE OUR LIFT HAS A TOTAL CAPACITY LIMIT OF 800 lbs.

Who do we contact in case of an Emergency?

Name and Relationship	Primary Contact number
Name and Relationship	Primary Contact number

Do you ever need to bring someone with you to help you when you travel (a "personal care assistant" or "personal attendant")?

❑ Yes ❑ No

Is your Care Assistant/Attendant hired through an Agency?

❑ Yes ❑ No

Please provide the information for your Care Assistant/Attendant	
Name of Agency:	Office Number:
Name of Assistant/Attendant:	Contact

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WITHOUT THE HELP OF SOMEONE ELSE CAN YOU….

1. Ask for and understand written or spoken instructions?

❑ Always ❑ Sometimes ❑ Never ❑ Not Sure

2. Cross the street?

❑ Always ❑ Sometimes ❑ Never ❑ Not Sure

3. Stand for 10 minutes if there is no place to sit?

❑ Always ❑ Sometimes ❑ Never ❑ Not Sure

4. Step on the sidewalk from the curb?

❑ Always ❑ Sometimes ❑ Never ❑ Not Sure

5. Find your own way to the FIXED ROUTE bus stop if someone shows you once or twice?

❑ Always ❑ Sometimes ❑ Never ❑ Not Sure

6. Walk up and down three steps if there is a handrail?

❑ Always ❑ Sometimes ❑ Never ❑ Not Sure

Under the best of conditions, what is the FARTHEST you can walk outdoors (or travel using your mobility aid) without the help of another person?

❑ Less than 1 block
❑ 1 block
❑ 2 blocks (1/4 mile)
❑ 4 blocks (1/2 mile)
❑ 6 blocks (3/4 mile)
❑ More than 6 blocks
❑ I cannot travel outdoors alone at all

*****Section A - to be completed by the Applicant*****

A. **I understand that the purpose of this application is to determine if I am eligible to use Paratransit Services. I certify that the information provided in this application is true and correct.**
I understand falsification of information could result in loss of Paratransit services.
I agree to notify ATCOG if I no longer need to use ADA Paratransit Services.

______________________________ Date________________
(Printed Name of Applicant)

______________________________ Date________________
(Printed Name of Applicant)

____
(Signature of Applicant or Legal Guardian)

____
(Relationship to Applicant)

If someone assisted in completing this application, please provide the following information:

Printed name	
Relationship to Applicant	
Address	
Agency (if applicable)	Phone

*****Section B - must be completed by a MEDICAL Doctor*****

Please list all the disabilities or impairments that prevent the applicant from being able to use a FIXED ROUTE bus service

How long do you expect the applicant's disability/impairment to continue?

❑ _____ Weeks | ❑ ________ Months | ❑ _______ years | ❑ Indefinitely

I hereby certify that I am a treating Medical Doctor of the Applicant for which this form is submitted and all answers pertaining to disabilities and health conditions provided are true and valid.

Signature of Medical Doctor — Date: _____________

Printed Name of Medical Doctor — Date: _____________

Medical License Number	Facility Name and Number

For ATCOG Transportation OFFICE USE ONLY

Authorizing Agent	❑ Approved ❑ Denied	Recertification due: / /
Reason for Denial (if applicable)		

ANY APPLICANT WHO IS DENIED ELIGIBILITY HAVE 60 DAYS TO APPEAL THIS DECISION IN WRITING.

Please send all Appeals to:

Ark-Tex Council of Governments

Attn: Paratransit - Appeal

1610 Clarksville St Paris, TX 75460