

Waco Transit System, Inc.

Dear Transit Passenger:

Your Waco Transit application and certification materials are enclosed. The Application Form requesting information concerning your disability and mobility is to be completed by you. The Certification Form is to be completed by your physician or a representative of an agency listed below.

1. DARS- Division for Blind Services
2. DARS- Division for Rehabilitation Services
3. Mental Health and Mental Retardation Center Heart of Texas Region
4. Brazos Kidney Disease Center

Please ask the physician or agency to return the certification form to you. When the certification is returned from your certifier, mail both the Application Form and Certification Form to Waco Transit. It is very important that all of the requested information be furnished. Incomplete information on either the application or certification will result in your forms being returned to you for proper completion, creating unnecessary delays in processing your request for service. If we are requesting your recertification as an eligible rider and we do not receive your recertification application within thirty (30) days, we will assume you no longer require service and your name will be removed from our list of eligible riders. Waco Transit will inform you of your eligibility status within three weeks of the return of your fully completed application materials.

If it is determined that you are eligible to ride Waco Transit, you will receive a Special Van Service Identification Card and Rider's Guide. The identification card will allow you to use similar services in other cities that have transit systems. If it is determined that you are not eligible to ride Waco Transit you will have the option of appealing the decision. The steps of the appeal process are as followed: You the individual will contact the Director of Operations & go through a physical assessment. If the decision is still denial, then the General Manager reviews the processes of the decision, of the Director of Operations. If the decision is still denial, then you the individual will present your case to the Transit Board.

Should you have any questions or require an application in an alternative format, please feel free to call our office at 750 -1621 for assistance.

Sincerely,

John Hendrickson
General Manager

Waco Transit System, Inc.

APPLICATION FOR SPECIAL VAN TRANSPORTATION SERVICE
Application form to be filled out by applicant or person assisting applicant
PLEASE TYPE OR PRINT

Please return Application and Certification to:
Waco Transit System, Inc., 301 South 8th Street, Suite 100, Waco, Texas 76701

The following information is requested so that Waco Transit System may determine whether or not you qualify to use the Special Van Transportation Service. Incomplete forms will be returned to you for completion.

Name: _____ / _____ / _____
LAST FIRST MIDDLE

Social Security Number _____ - _____ - _____ Male () Female ()

Home Address: _____
Street or Box Address

_____ City State Zip

Mailing Address (if different): _____

Birth date: ____/____/____ Home Phone:()____-_____
Work Phone:()____-____ Place of Employment: _____

Name of Emergency Contact: _____ Phone:()____-_____
Emergency Contact Address: _____

Describe the disability, which causes your mobility to be limited.

Does your disability prevent you from using Waco Transit's regular bus system?
Yes () No ()

Waco Transit System, Inc.

If so, please explain completely why you cannot ride the bus:

Are there any other affects of your disability of which we should be aware?

Is the mobility impairment permanent_____ or temporary_____? If temporary, the condition will last until _____.

Do you use any of the following mobility aids? (Check all that apply)

Manual Wheelchair	___	Electric Wheelchair	___
Powered Scooter	___	Cane	___
Crutches	___	Service Animal	___
Walker	___	Other	_____

Do you require an attendant to assist you in travelling?

Never___ Sometimes___ Always___

Is your residence equipped with a wheelchair ramp? Yes () No()

How far can you walk or wheel yourself without assistance from another person?

No distance	()	Up to 200 feet	()
Up to 400 feet (2 city blocks)	()	Up to 1/4 mile (4 blocks)	()
Up to 1/2 mile (6 blocks)	()	Up to 3/4 mile (11 blocks)	()

Can you climb three 12-inch steps without assistance? Yes () No ()

Can you wait outside without support for ten minutes? Yes () No ()

Waco Transit System, Inc.

Please read the acknowledgement and sign the application form. When your certification form is returned to you from your certifier, please return both the application and certification forms to Waco Transit System, Inc.

ACKNOWLEDGEMENT

I agree to pay the exact fare for each trip. I agree to notify Waco Transit of any changes in my mobility status, which may affect my eligibility to use the service. I also understand that failure to adhere to the policies and procedures will be grounds for suspending or revoking my application and right to use the Waco Transit service. I understand and agree to hold Waco Transit System harmless against all claims or liability for damages to any person, property, or personal injury occurring as a result of my failure to equip or maintain the safety measures of the adaptive equipment or service animal that I require for mobility. I have read and fully understand the conditions for service outlined above and agree to abide by them.

Applicant's signature: _____ Date: ____ / ____ / ____

If this application has been completed by someone other than the person requesting certification, that person must complete the following:

Name: _____	Daytime phone: _____
Address: _____	
City: _____	St: _____ Zip _____
Signed _____	Date _____

OFFICE USE ONLY:

DATE APPLICATION RECV'D: _____

APPROVAL OR REJECTION DATE: _____

DATE APPLICANT NOTIFIED: _____

Waco Transit System, Inc.

Medical Provider Certification Form

(PAGE 4 & 5 MUST BE FILLED OUT BY A PHYSICIAN OR CERTIFIED AGENCY ONLY)

Please Type or Print
Medical Certifier:

Please fill out this form completely and return it to the applicant when completed. Incomplete forms may result in delays to the applicant. Thank You.

Name of Applicant _____

WHAT IS THE MEDICAL DIAGNOSIS THAT CAUSES THE DISABILITY? (IF MENTAL RETARDATION - LIST I.Q.)

Should the Certification be Permanent () or Temporary ()? If temporary, how long will applicant require the service? Ending date of temporary disability: ____/____/____

If the person has a disability affecting mobility check the distance he or she can walk or wheel him or herself in a wheelchair without assistance:

No distance	Yes() No()	200 feet	Yes() No()
600 feet (2 city blocks)	Yes() No()	1/4 mile (4 blocks)	Yes() No()
1/2 mile (6 blocks)	Yes() No()	3/4 mile (11 blocks)	Yes() No()

Is the person able to climb three 12-inch steps without assistance? Yes() No()

Is the person able to wait outside without support for 10 minutes? Yes() No()

Does the applicant use any of the following mobility aids? (Please check all that apply)

Manual Wheelchair_____	Electric Wheelchair_____	Walker_____
Cane _____	Crutches_____	Powered Scooter _____
Service Animal_____	Other _____	

Does the applicant require a personal care attendant?

Never_____ Sometimes_____ Always_____

If necessary, can the applicant be transferred from a wheelchair to a passenger seat? Yes() No()

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If vision impaired, what is **Best Corrected Acuity** (Snell)?

Right eye _____ Left eye _____

Visual Field Restriction: Right _____ Left _____

Visual impairment diagnosis: -

If the applicant has a cognitive disability, is the applicant able to:

1. Give addresses and telephone numbers upon request? Yes () No ()
2. Recognize a destination or landmark? Yes () No ()
3. Deal with unexpected situations or unexpected change in routine? Yes () No ()
4. Ask for, understand and follow directions? Yes () No ()
5. Safely travel through crowded and/or complex facilities? Yes () No ()

Additional comments? _____

PROFESSIONAL CERTIFICATION

Qualified professional must complete this section. Please print or type.

Person Completing Form: _____

Professional Title: _____

Agency/Affiliation: _____

Business Address: _____

City: _____ State _____ Zip _____ Phone() _____ -

I verify that the information provided above is true and correct to the best of my knowledge.

Signature of Qualified Professional

Date

Please return to: Waco Transit System, 301 South 8th Street, Suite 100, Waco, TX 76701, 753-0115.