Monroe Transit System
Paratransit Eligibility Application

Introduction

The Monroe Transit System (MTS) has updated its Paratransit eligibility application process effective June 9, 2018. The new process includes two parts: a completed application by the applicant and a healthcare professional authorization.

The MTS Paratransit Eligibility Application will be used to determine which MTS service best meets your needs. Some individuals with disabilities will be able to use fixed route transit as a result of new accessible features offered by Monroe Transit fixed route buses:

- All buses are equipped with lifts and an announcement system that identifies major bus stops.
- All buses offer priority seating areas for seniors and persons with disabilities, and two wheelchair positions with seatbelts.
- Many buses offer a kneeler feature making stepping onto the bus easier

Other persons will require Paratransit services for some or all of their transportation needs. The Paratransit service is origin to destination, shared ride public transportation service for individuals who are prevented from using fixed route service due to their disability.
**Directions**

**Application**
The first step in the evolution process is to submit the Paratransit Eligibility Application form (pages3-8). The applicant must complete the entire evaluation form, including the Healthcare Professional Authorization Release Form.  
*Be sure to complete every item and sign the release forms.* The application must be complete before MTS can proceed with the review process. If any portion of the application or the release forms is not completed, the application will be returned to the applicant.

If you need assistance in completing the application or need the application provided in an alternate format, please call MTS at 318-329-2506, and we will be happy to assist you. Applications must be mailed to:

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Monroe Transit: Paratransit Program  
700 Washington Street  
Monroe, La 71201
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MTS is not responsible for applications sent to any other address or faxed.

**Healthcare Professional Authorization**
Once the complete application is received, MTS will mail a Healthcare Professional Certification to the person named on the applicants authorization form. After the certification form is returned, the application will be reviewed by MTS.

**Eligibility Certification**
MTS will make a determination as to which transit service the applicant can receive and will notify the applicant within 21days of receipt of the Healthcare Professional Authorization. If you do not receive a decision on your application within 21 days you are automatically certified for transportation until a determination is made.

**Privacy Statement**
The information obtained by MTS in the application process will only be used by MTS and the Federal Transit Administration for provision of public transit services. The information will be kept confidential and will not be provided to any other persons or agencies.
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Part 1  General Information
Do you need the application and future written information from MTS provided in an accessible format?  Yes_______  No_________

If yes, specify the format you prefer: __________________________

It is important to complete all parts of this form. Please type or print. Applications that are not fully completed or legible will be returned.

Name: ____________________________________________________________
First                Middle                Last

Date of Birth: ______________

Home Address: _____________________________________________________
Street            Apt#

Home City: _______________________________________________________
City                State            Zip

Applicant’s Phone: Daytime: __________________________ Evening ______________

Closest Cross Street(s): ____________________________________________

Closest Bus Stop(s): _______________________________________________

Mailing Address (if not home): _______________________________________
City: ________________  State: ________    Zip: _____________

Frequent Destination(s)     Closest Bus Stop(s)
__________________________  ___________________________
__________________________  ___________________________


Monroe Transit System  
Paratransit Eligibility Application

Emergency Contact Name: ______________________    Relation: ____________

Work Phone: _____________ Home Phone: _____________ Cell: _____________

If assistance was provided in filling out this form, please indicate by whom:

Name: __________________Day Phone: ________________ Relation: ________

Is this the person to contact if additional information is needed? Yes____ No_____

Part 2- Transit Needs Evaluation

1. Are you able to ride an ADA accessible fixed route bus?
   Yes _____     No_____    Sometimes ______   I don’t know ______

   a. If your answer is not YES, WHAT functional limitation(s) or health –
      related condition might impede or prevent you from using fixed route
      transit?

      _______________________________________________________________
      _______________________________________________________________
      _______________________________________________________________

   b. Explain HOW your functional limitation(s) or health-related condition might
      prevent you from using the fixed route transit services.

      _______________________________________________________________
      _______________________________________________________________
      _______________________________________________________________
      _______________________________________________________________

   c. Are the limitations/conditions you described permanent _______ or
temporary _______?
d. Does your health condition or transportation-related disability change from day to day in a way that affects your ability to use fixed route buses?
   Yes ________  No _________  Don’t Know ___________
   If yes or don’t know is selected, explain why: ________________________________

2. How do you currently travel to your most frequent destinations? Check all that apply:
   Fixed route buses_____  Paratransit _____  Medicaid_____  Taxi_____  
   Someone drives me_____  Drive myself_______  Other  (specify) ________

   For questions 3 through 12, please indicate whether you are independently able to perform the following functions. When answering “No” or “Sometimes”, an explanation is required or the application will be considered incomplete.

3. Are you able to understand directions needed to complete a trip? (This does not include being unaccustomed to English language.)
   Yes ____  No ____  Sometimes _____  If “No” or “Sometimes”, explain:

4. Are you able to identify the correct bus stop?
   Yes ____  No _____  Sometimes ____  If “No” or “Sometimes”, explain:

5. Are you able to identify the correct public transit vehicle (bus)?
   Yes _____ No _____  Sometimes _____  If “No” or “Sometimes”, explain:
6. Are you able to get to and from the nearest bus stop?
   Yes _____ No____ Sometimes _____ If “No” or “Sometimes”, explain:
   ____________________________________________
   ____________________________________________
   ____________________________________________

7. On a good day, how many city blocks can you travel
   without a mobility aid? ________________
   with a mobility aid? ________________
   Could you wait if there were a bench of bus shelter?
   Yes____ No _____ Sometimes _____ If “No” or “Sometimes”, explain:
   ____________________________________________
   ____________________________________________

8. Are you able to wait at least 15 minutes?
   Yes _____ No _____ Sometimes _____ If “No” or “Sometimes”, explain:
   ____________________________________________
   ____________________________________________

9. Are you able to get on or off a bus with a lift or when the bus is lowered?
   Yes _____ No _____ Sometimes _____ If “No” or “Sometimes”, explain:
   ____________________________________________
   ____________________________________________

10. Are you able to grasp handles or railings, coins or tickets while boarding or
    exiting a bus?
    ____________________________________________
    ____________________________________________
11. Are you able to maintain your balance when seated on the bus?
   Yes ____ No ____ Sometimes _____ If “No” or “Sometimes”, explain:
   __________________________________________________________
   __________________________________________________________

12. Have you ever had training or instruction on how to use Paratransit service?
   Yes ____ No _____
   a. If Yes, what person or agency provided the training? ____________
   b. If no, do you want or need training? Yes____ No ______

13. Can you transfer from your wheelchair to seat in a vehicle?
   Yes _____ No ______

14. Do you use any of the following mobility aids or equipment?
   ____ Cane             ____ Power Wheel Chair              ____ Communication Board
   ____ White Cane       ____ Larger Power Wheel Chair      ____ Service Animal
   ____ Walker           ____ Power Scooter (3-wheels)      ____ Leg Braces
   ____ Crutches         ____ Manual Wheel Chair           ____ Other ________

15. Does a personal care attendant (PCA) accompany you when you travel outside your home (i.e. to push your wheel chair, carry oxygen, etc.)?
   Yes _____ No ____ Sometimes _______ If “Yes” or “Sometimes”, explain:
   __________________________________________________________
   __________________________________________________________

16. Do you currently use Paratransit Service?
   Yes_____ No ____ Sometimes ______

   If “Yes” or “Sometimes” is selected, when do you use Paratransit Service?
   _____________________________
   _____________________________

   Please give Paratransit provider’s name: ______________________________
17. For your Paratransit needs, do you require to be picked up at your door instead of the curb?
   Yes____ No____ Sometimes____

   If “Sometimes” is selected please explain______________________________
   ___________________________________________________________________
   ___________________________________________________________________
Optional Information

The following information may be used to secure funding from other sources

Are you participating in or plan to participate in a WIA (Workforce Investment Act) Training program? Yes ____ No____
If YES, please give name of your WIA contact and phone number:
Contact Name ___________________ Phone : ______________

Are you participating in or plan to participate in an LRS (Louisiana Rehabilitation Service), Veterans Administration or Federal Vocational Rehabilitation training program? Yes____ No____
If YES, please give name of your counselor and phone number:
Counselor Name ___________________ Phone: ______________

Do you currently use Medicaid? Yes____ No _____

What are you primary transportation needs? Please check all that apply.
Work ______ Medical Appointments ______
Banking/Legal ______ Shopping ______
Education ______ Entertainment ______
Day Care ______ Address __________________________
Dialysis ______ Address __________________________

Applicant Certification (REQUIRED)

I certify that the information in this application is true and correct. I understand that falsification of the information may result in denial of some MTS services and/or discounts. I understand all information will be kept confidential, and only the information required to provide the services for which I am eligible will be disclosed to those who perform the services. I understand that it may be necessary to contact a licensed/certified healthcare or allied health professional familiar with functional abilities/health related conditions in order to assist in an accurate application review. I also acknowledge that I have received the MTS Paratransit Ride Guide and agree to comply with all rules and regulations of MTS.

Applicants signature _______________________ Date : ______________
Signature of person assisting in completing application________ Date:______
Monroe Transit System
Healthcare Professional Authorization Release Form

I hereby authorize____________________________________________________
(Print name of licensed physician, licensed nurse practitioner, or state licensed or
nationally certified allied health /rehabilitation professional familiar with your
transit related limitations or health related condition)

Mailing Address:_____________________________________________________

City: _______________ State: _________ Zip: ________________

Phone: ______________________ Fax: _____________________

To release to Monroe Transit System necessary information about my functional
limitation(s) and/or health related condition that affect my ability to use public
transit. This information combined with my application will be used to determine
the type(s) of public transportation I am eligible for.

• All released information will be kept confidential and must only on a need to
  know basis.
• I have the right to receive a copy of this authorization.
• I understand that I may revoke this authorization at any time.

_________________________________ ________________________
Name of applicant (print) Date Signed

_________________________________
Applicant’s Signature