Eligibility Application for Complimentary ADA Paratransit Services

OFFICE USE ONLY

Date Received _____

Date Processed _____

Date Approved _____

Date Denied _____

Date Notified _____

Status Code _____

*****EFFECTIVE FEBRUARY 1, 2022 ALL NEW APPLICANTS MUST LIVE WITHIN 3/4 MILE OF A FIXED ROUTE TO BE CONSIDERED FOR ELIGIBILITY*****

1. **ADA Category 1**: A person who is unable to board, ride, or exit any vehicle independently on the fixed route system that is readily accessible to and usable by persons with disabilities.
2. **ADA Category 2**: A person who needs the assistance of a wheelchair lift and one is not available on the fixed route service during the time the individual wishes to travel. (All fixed route vehicles are fully accessible).
3. **ADA Category 3**: A person who has an impairment-related condition that prevents getting to or leaving a bus stop.
4. If all spaces are not completed this form will be returned.
5. Please read the entire application and print neatly or type; only one person per application.
   This application is available in accessible format. If you have any questions regarding this application or need assistance completing the form, please call (615) 801-3039, or TDD (615) 849-2689.

Section 1—Personal Information

Date of Application: _____

Name (Please Print): _____

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Work/Cell Telephone: _____

Birth Date: _____ Email Address: _____

Emergency Contact (Application will be returned if left blank.)

Name: (Please Print): _____

Address: _____

Home Telephone: _____ Work/Cell Telephone: _____

Relationship: _____

I certify that information provided in this application is true, authorize the health care professional certifying this application to release information about my disability to Murfreesboro Transit and Mid-Cumberland Human Resource Services

Applicant's Signature: _____

If this application has been completed by someone other than the person requesting reduced-fare eligibility, that person MUST FULLY COMPLETE the following:

Name of Individual or Agency: _____

Address: _____

(City / State / Zip): _____

Phone: Fax Number: _____

Signed: _____ Date: _____

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Section 2—Disability Information

1. Please describe your impairment and/or illness and check any applicable items below (examples include blindness, multiple sclerosis, heart condition): _____
_____

a. Visually Impaired: Total _____ Partial _____ Vision: Right 20/_____ Left 20/ _____
b. Hearing Impaired: _____
c. Mentally or Developmentally Impaired: _____
d. Mobility Device: Powered _____ Manual _____ Scooter _____
e. Crutches: Braces _____ Walker _____ Prosthesis _____ Other _____
f. Other Mobility Limitations or Physical Impairments (please describe): _____
_____
_____

2. Do you require someone to assist you when you travel using transit? (It is a disabled rider's responsibility to provide a personal care attendant and a properly functioning mobility device. No fare is charged for a personal care attendant riding with a disabled rider.)
(*Do not leave blank)* YES ____ NO ____

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

____ Wheelchair; if Your Wheelchair Is Larger Than a Common Wheelchair (30 Inches Wide; 48 Inches Long ; more than 600 lbs. when occupied), please describe it:_____
_____
_____

____ Powered Scooter. If you use a scooter, will you be able to transfer to a seat? Yes ____ No ____
____ Service Animal ____ Alphabet Board ____ Oxygen Tank
____ Other Assistive Devices. If yes, please describe: _____

_____

_____

Section 3—Health Care Professional Certification

This certification must be completed by a licensed or certified health care professional , and received by Murfreesboro Transit within 60 days of the health care professional's signature. Information will remain on file and is not subject to public review.

Name of Health Care Professional: _____
License Number/State Issued: _____Phone: _____
Address: _____
City, State, Zip: _____

Check One: ____Physician: (Specialty) _____
_____ Physician's Assistant _____Nurse Practitioner _____Audiologist _____ Podiatrist
_____ Optometrist _____ Licensed Clinical Psychologist _____Certified School Psychologist
_____ Licensed Occupational Therapist _____ Licensed Physical Therapist

Expected duration of applicant's disability:
_____ Temporary: Short Term conditions likely to improve within one year
_____ Long-Term: Condition with potential for improvement or log periods of remission
_____ Permanent: Conditions with absolutely no expectation of improvement

I certify that the applicant is affected by the impairment/illness described, and as a result, requires the assistive devices described, and is unable to use mass transportation services as effectively as persons who are not so affected.

Signature: _____Date: _____

Please Return Application to:
Transit Eligibility Coordinator
4765 Florence Road
Murfreesboro, TN 37129

ATTACHMENT 2

COMPLIMENT, COMPLAINT AND SUGGESTION FORM

Name_____
Phone Number_____
Address_____
_____

Please select one of the following
Compliment ☐
Complaint ☐
Suggestion ☐

Date of service_____

In the space below please provide a description of the event. Please provide as much detail, including the names of all parties and places involved.

_____
_____
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Mail the completed form to:
Murfreesboro Transit
111 West Vine St.
Murfreesboro, TN 37130
Attn: Assistant Transportation Director