JATRAN

The Driving Force of Jackson

PTM of Jackson, Inc.

Dear Applicant,

The enclosed forms must be filled out completely in order for JATRAN to determine whether you are eligible for paratransit service. After careful review, you will receive a letter of notification indicating whether paratransit service has been approved or denied.

Please follow the guidelines as indicated:

- Handilift Paratransit Eligibility Form - *applicant must complete form*
- Medical Verification of Disability Form - *physician must complete form*

Mail forms to this address:

JATRAN Handilift
P.O. Box 2809
Jackson, MS 39207-2809

If you have questions, please contact our office at 601-948-3840.

Sincerely,

Handilift Coordinator

Enclosures: Handilift Paratransit Eligibility Certification Form
Medical Verification of Disability Form

PTM OF JACKSON, INC.

Handilift Paratransit Eligibility Certification

The information obtained in the certification process will only be used by JATRAN Handilift service for the provision of transportation services. Information will only be shared with other transit providers to facilitate travel in those areas. The information will not be provided to any other person or agency.

The following information will be used to ensure an appropriate vehicle is utilized to provide your transportation and that accurate analysis of your trip request can be made by JATRAN Handilift service.

Please Print or Type

Date: _____

1. Name: _____
2. Address: _____
   _____
3. Phone #: Home: _____ Cell/Other: _____
   Work: _____ Email: _____
4. Date of Birth ___/___/___
5. Explain the reason why your disability prevents you from riding JATRAN's fixed route service?
   _____
   _____
   _____

Is this condition temporary? ☐ **No** ☐ **YES** If **YES**, expected duration until ___/___/___

6. Please explain how this disability prevents you from using fixed route services?
   _____
   _____
   _____
7. Are there any other issues related to your disability that JATRAN should be aware of?
   _____
   _____
   _____

8. Do you require any of the following aids for mobility? **(Check all that apply)**

☐ Cane ☐ Electric wheelchair ☐ Powered scooter
☐ Crutches ☐ Personal care attendant ☐ Guide dog
☐ Manual wheelchair

9. Do you require a "Personal Care Attendant when traveling using transit?

☐ Yes ☐ No

10. Please answer the following questions:

Can you travel 200 feet without the assistance of another person?

☐ Yes ☐ No

Can you travel ¼ mile without the assistance of another person?

☐ Yes ☐ No

Can you climb three (3) 12-inch steps without assistance?

☐ Yes ☐ No

Can you wait outside without support for ten minutes?

☐ Yes ☐ No

11. I herby certify that the information given above is correct.

_____ _____

Applicant Signature Date

Mail Form To

JATRAN Handilift
P.O. Box 2809, Jackson, MS 39207-2809

If you have any questions, please call **601-948-3840**

PTM OF JACKSON, INC.

Medical Verification of Disability

Dear Medical Professional,

The Medical Verification of Disability form is being submitted by your patient who has indicated that you can provide information regarding his/her disability and its impact upon his/her ability to utilize JATRAN's transit services. Federal law requires JATRAN Handilift service to provide paratransit service to persons who cannot utilize available fixed route service. The information being requested will allow JATRAN to make an appropriate evaluation of this request and its application to a specific trip request. We appreciate your cooperation in this matter.

Date: _____

Please Print /Type

Patient's Name:

What is the applicant's capacity? _____

Medical diagnosis of condition causing disability _____

Is this condition temporary? _____

If yes, expected duration until _____

_____

If the person has a disability effecting mobility

Is this person:

Able to walk 200 feet without assistance? ☐ Yes ☐ No

Sometimes (explain) _____

Able to walk ¼ mile without assistance? ☐ Yes ☐ No

Sometimes (explain) _____

Able to climb three (3) 12-inch steps without assistance? ☐ Yes ☐ No

Sometimes (explain) _____

Does the person use any mobility aids? If so, describe?

_____

If the patient has a cognitive disability

Is the person able to:

Provide address and telephone number upon request? ☐ Yes ☐ No

Recognize a destination or landmark signage? ☐ Yes ☐ No

Handle unexpected situations or changes in his/her routine? ☐ Yes ☐ No

Inquire, understand, and follow directions? ☐ Yes ☐ No

Safely and effectively travel through crowded and/or complex facilities? ☐ Yes ☐ No

Please provide any other disability issues that JATRAN would need to take into consideration.

_____

_____

Physician Contact Information

Name: _____

Office Address: _____

_____

Phone #: _____

Office: _____

_____ _____

Physician Signature *Date*

Mail Form To

JATRAN Handilift
P.O. Box 2809, Jackson, MS 39207-2809

If you have any questions, please call **601-948-3840**