THE CITY OF JACKSON, MS
JATRAN HANDILIFT 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 agencies without the consent of the applicant.

Anyone who is permanently or temporarily mobility impaired, generally defined as a person of any age who is functionally unable to use the regularly scheduled fixed route system for one or more of the following reasons:

- Unable to utilize a regular public transit bus. ("Unable" means that performing the function is absolutely impossible or causes severe, continuing pain; it does not mean discomfort or occasional pain).
- Unable to walk from place of origin or destination to the nearest bus stop.
- Unable to utilize a regular public transit bus to reach a source of life sustaining activities.

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.

GENERAL INFORMATION (Please Print)

First Name _____ Middle Initial _____ Date _____

Last Name _____ Sex: M _____ F _____ DOB _____

Address _____ City _____

State _____ Zip _____ County _____

Phone _____ Email _____

Mailing Address (if different) _____

City _____ Zip _____ County _____

DISABILITY AND MOBILITY EQUIPMENT INFORMATION

Explain the reason why your disability prevents you from riding JATRAN's fixed route service?

_____

_____

_____

Is this condition temporary? Yes ____ or No____ If YES, expected duration until _____

Are there any other issues related to your disability that JATRAN should be aware of?

_____

_____

_____

Do you use any mobility aids or equipment? (Check all that apply.)

___ Cane

___ Crutches

___ Walker

___ Leg Brace

___ Prosthesis

___ Portable Oxygen

___ Powered Wheelchair

___ Powered Scooter

___ Manual Wheelchair

___ Long White Cane

___ Service Animal

___ I do not use any of these mobility aids.

___ Other (please specify) _____

Do you ever need to bring someone with you to help you when you travel (a "personal care assistant" or "personal attendant")? ____ Yes, I always ____ Yes, sometimes ____ No

ABILITIES TO USE FIXED ROUTE BUSES

Please read the following statements and check those which best describe your abilities to use fixed route buses. (Check all that apply.)

____ I can get to and from bus stops, if the distance is not too great.

____ I can ride the buses when I am feeling well. There are other times, however, when my

disability or health condition worsens, and at these times I cannot ride the buses.

____ I have a disability or health condition that prevents me from riding the buses if the weather is very hot or very cold.

____ My disability or health condition makes it impossible to travel when there is ice on the ground.

____ I cannot climb stairs to get on and off fixed route buses and in and out of bus stations.

____ I can get to and from bus stops and bus station only if there are curb cuts and level sidewalks.

____ I have difficulty understanding or remembering all the things I would have to do to use the buses.

____ I can use fixed route buses by myself.

____ I can use fixed route buses if it's someplace I go all the time.

____ I'm not really sure if I can use fixed route buses.

____ I'm not able to use fixed route buses for other reasons. Please explain:

_____

_____

_____

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 ____

I understand that the purpose of this application is to determine if I am eligible to use the City of Jackson's JATRAN Paratransit Services. I certify that the information provided in this application is true and correct. I understand that falsification of information could result in a loss of paratransit services, as well as, a penalty under the law. I agree to notify the City of Jackson's Transit Services Division or JATRAN, if I no longer need to utilize services.

_____ _____

Applicant Signature Date

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

Print Name _____

Relationship to applicant _____

Address _____

Agency _____ Phone (_____) _____

Once your application has been submitted and approved, you may contact JATRAN's Maintenance Facility to schedule a trip at either of the two numbers below:

1. 601-952-1000
2. 601-960-0725

Hand-deliver, mail or fax to:
JATRAN Administrative Office
1785 Highway 80 West
Jackson, MS 39201
Fax: 601-948-3840

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 or Type

Patient's Name _____

What is the applicant's capacity? _____ Is this condition temporary? _____

If yes, expected duration until _____

Medical diagnosis of condition causing disability _____

_____

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 ____

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.

_____

_____

In order for Transit Services to evaluate your request for eligibility, it may be helpful for us to contact a professional who is familiar with your health condition or disability and your functional abilities and limitations. Please list a professional who we can contact if we need additional information. Examples of qualified professionals include:

physician (M.D. or D.O.)	independent living specialist	ophthalmologist
physical therapist	rehabilitation specialist	psychiatrist
occupational therapist	social worker	psychologist
registered nurse	case manager	orientation and mobility instructor

Name of qualified professional _____ Phone _____
Professional's agency _____ Type of professional _____
Street Address _____ City, State & Zip _____

_____ _____
Physician/Certifier Signature Date

Authorization for Release of Information

I authorize the professional(s) listed above to release to the Transit Services Division information about my disability or health condition and its effect on my ability to travel on the JATRAN bus system. I understand that I may revoke this authorization at any time. Unless earlier revoke, this form will permit the professional listed to release the information described up to 90 days from the date below.

_____ _____
Signature of Application or Responsible Party Date

Hand-deliver, mail or fax to:
JATRAN Administrative Office
1785 Highway 80 West
Jackson, MS 39201
Fax: 601-948-3840