



## **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 (pages 3-8). 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:

Monroe Transit: Paratransit Program  
700 Washington Street  
Monroe, La 71201

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 21 days 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.

**Monroe Transit System  
Paratransit Eligibility Application**

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: \_\_\_\_\_

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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:

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4. Are you able to identify the correct bus stop?

Yes \_\_\_\_ No \_\_\_\_ Sometimes \_\_\_\_ If "No" or "Sometimes", explain:

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5. Are you able to identify the correct public transit vehicle (bus)?

Yes \_\_\_\_ No \_\_\_\_ Sometimes \_\_\_\_ If "No" or "Sometimes", explain:

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6. Are you able to get to and from the nearest bus stop?  
Yes \_\_\_\_\_ No \_\_\_\_\_ Sometimes \_\_\_\_\_ If "No" or "Sometimes", explain:

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7. On a good day, how many city blocks can you travel  
without a mobility aid? \_\_\_\_\_  
with a mobility aid? \_\_\_\_\_

8. Are you able to wait at least 15 minutes?  
Yes \_\_\_\_\_ No \_\_\_\_\_ Sometimes \_\_\_\_\_ If "No" or "Sometimes", explain:

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Could you wait if there were a bench or bus shelter?  
Yes \_\_\_\_\_ No \_\_\_\_\_ Sometimes \_\_\_\_\_ If "No" or "Sometimes", explain:

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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:

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10. Are you able to grasp handles or railings, coins or tickets while boarding or  
exiting a bus?

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11. Are you able to maintain your balance when seated on the bus?  
Yes \_\_\_ No \_\_\_ Sometimes \_\_\_\_\_ If "No" or "Sometimes", explain:

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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:

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16. Do you currently use Paratransit Service?

Yes \_\_\_ No \_\_\_ Sometimes \_\_\_\_\_

If "Yes" or "Sometimes" is selected, when do you use Paratransit Service?

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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\_\_\_\_\_

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**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

