The Americans with Disabilities Act of 1990 (ADA) is a civil rights bill that bans discrimination against people with disabilities. To meet their needs, public transit systems must provide a variety of services.

If you have a disability that prevents you from using a ramp or lift-equipped public transit bus some or all of the time, you may be eligible for ADA Paratransit service some or all of the time.

All information will be kept confidential. Only the information required to provide the services you request will be disclosed to those who perform those services. Your answers will not be shared with any other person or company.

It is important that all parts of this form are completed. If the application is not complete, it will be returned to you and that will delay having your application processed.

Please use the envelope provided or return to:

Terrebonne Parish Consolidated Government
Transit Division
Administrative Coordinator II
Post Office Box 2768
Houma, Louisiana 70361

If you have any questions, please call 985-850-4616.
SECTION 1. PERSONAL INFORMATION

PLEASE PRINT

Last Name ___________________________ First Name ___________________________ Initial ___________________________

Physical Address ___________________________ City ___________________________ Zip ___________________________

Mailing Address (if different) ___________________________ City ___________________________ Zip ___________________________

Date of Birth: ____/____/____ Male □ Female □

Daytime Phone ___________________________ Evening Phone ___________________________

TDD* ___________________________

Language Ability (please check all that apply)
□ English □ Other (specify) ___________________________

Emergency Contact Name ___________________________ Relationship ___________________________

Daytime Phone ___________________________ Evening Phone ___________________________

* Telecommunications Device for the Deaf

Email Address (optional) ___________________________
SECTION 2. MOBILITY INFORMATION

1. Which of these mobility aids or equipment do you use to help you get to where you need to go? (Please check all that apply to you.)

- None
- Cane
- Manual Wheelchair
- Service Dog
- White Cane
- Power Wheelchair
- Picture Board
- Walker
- Powered Scooter/Cart
- Alphabet Board
- Crutches
- Portable Oxygen
- Other

2. Using a mobility aid or on your own, how many blocks can you go on level ground?

- Less than 2
- 2 to 4
- More than 4

3. If you were to ride the fixed-route bus would you need the assistance of another?
   If answered Always or Sometimes, then explain reason for assistance in box.

- Always
  - To help me get to or from the bus stop.
- Sometimes
  - To help me get on or off the bus
- No
  - Other

4. Have you ever had any training to learn how to use the fixed-route transit bus?
   If answered yes, then provide additional information in box.

- Yes
  - The training was at:
    - General Bus Travel
    - How to ride specific routes
    - I finished the training
    - I did not complete the training
- No
  - No, but I am interested in learning more about the travel training program.

5. If you are found eligible for paratransit services, check appropriate statements.

- I am able to meet the van at the curb at my home without assistance.
- I need assistance from my door to the van at the curb.
- I need assistance from the van to the door of my destination.
- I would sometimes need assistance to or from the van when,
  - I will notify Good Earth Transit when booking my trip if I need additional assistance beyond the curb.
  - Explain why and when you will need additional assistance.
6. Please list your five most frequent trips, and how you get there now?

1. 

2. 

3. 

4. 

5. 

SECTION 3. DISABILITY OR HEALTH CONDITION INFORMATION

Indicate all conditions that affect your ability to use the bus.

1. General Medical Conditions
   - None
   - Cancer
   - Kidney Failure
   - Diabetes
   - Organ Transplant
   - Other

2. Bone and Joint Conditions
   - None
   - Amputation of:
     - Ankylosing Spondylitis
     - Broken Bone
     - Arthritis
     - Fusion
     - Osteo-arthritis
     - Osteoporosis
   - Other

3. Brain / Nerves / Muscle Conditions
   - None
   - Alzheimer’s Disease
   - Hemiplegia
   - Post-polio
   - Brain Injury
   - Huntington’s Chorea
   - Quadriplegia
   - Cerebral Palsy
   - Multiple Sclerosis
   - Spina Bifida
   - Dementia
   - Muscular Dystrophy
   - Stroke
   - Epilepsy
   - Paraplegia
   - Vertigo/Dizziness
   - Guillain-Barre
   - Parkinson’s Disease
   - Other
4. Heart and Circulatory Conditions
   - None
   - Angina
   - Congestive Heart Failure
   - Edema
   - Other
   - Heart Attack
   - Peripheral Vascular Disease
   - High Blood Pressure

5. Lung and Breathing Conditions
   - None
   - Allergies
   - Chronic Obstructive Pulmonary Disease (COPD)
   - Emphysema
   - Asthma
   - Cystic Fibrosis
   - Lung Cancer
   - Other

6. Vision / Hearing / Speech Conditions
   - None
   - Aphasia
   - Cataracts
   - Deaf-Blind
   - Diabetic Retinopathy
   - Other
   - Glaucoma
   - Legally Blind
   - Deaf
   - Night Blindness
   - Other

7. Developmental / Mental Conditions
   - None
   - Autism
   - Developmental Disability
     - Mild
     - Moderated
     - Severe
   - Other
   - Dwarfism
   - Mental Retardation:
     - Mild
     - Moderate
     - Severe
   - Mood Disorder
   - Psychosis
   - Thought Disorder

8. Is your health condition or disability temporary?
   - Yes
     - How long do you expect it to last?
     - Number of years: ____________
   - No
     - How long have you had this condition or disability?
     - Since birth
     - Number of years: ____________
   - I don’t know
9. Does your disability or health condition change from time to time in ways which affect your ability to use the bus?

- Yes

Please Describe:

- No

SECTION 4. FIXED ROUTE BUS USE INFORMATION

(Please answer all questions even if you do not ride the regular fixed route bus.)

1. Do you ride regular (fixed-route) bus service?

- Yes

How many days per week? __________

How many days per month? __________

- No

- No, but I used to ride the bus

2. Can you communicate with a bus driver yourself or with the help of an aid (such as a letter board or bus route ID cards)?

- Yes

- No

Please check all that apply.

- I cannot understand the driver
- I need a communication aid and don’t have one
- Other people cannot understand me
- Other

3. How many blocks do you need to go to get to a bus stop?

- Less than 2
- 2 to 4
- More than 4
- Don’t know

4. Using a mobility aid or on your own, can you make your way to the bus stop?

- Yes

Please check all that apply.

- I can’t find the stop because I get confused
- I need someone to help me get there
- I could with training
- I don’t want to ride the fixed route service buses
- The ground is too uneven for me to get there
- I can’t go that far
- Heavy rain makes it impossible for me to get there
- Other
5. Can you wait 10 minutes at a bus stop that does not have seats and a shelter?

- Yes
- No

Please check all that apply.

- I get too confused and might get lost
- I don’t like to wait that long
- Standing for 10 minutes makes me too tired to ride the bus
- Very cold weather is dangerous to my health
- Very hot weather is dangerous to my health
- Other

- No, but I could wait for 10 minutes at a stop which does have seats and a shelter.

6. Do you know where to get off the bus or can you find out?

- Yes
- No

Please check all that apply.

- I get confused or can’t remember where I’m going
- I don’t know where the bus stop is
- I need a communication aid and don’t have one
- I could with training
- Other

7. From where the bus stops to let you get off, can you make your way to the place you need to go?

- Yes
- No

Please check all that apply.

- I get confused or can’t remember where I’m going
- I need someone to help me get there
- I feel unsafe there
- I don’t want to ride the bus
- The ground is too uneven or steep for me to get there
- I can’t walk that far
- I could with training
- Other
8. Are there any other conditions which limit your ability to use the bus?

- [ ] Yes
- [x] No
SECTION 5. APPLICANT SIGNATURE

Do not detach—must be submitted with application

1. I certify that the information I gave in this application is true and correct. I understand that falsification of information may result in denial of service. I understand all information will be kept confidential, and only the information required to provide the services I request will be disclosed to those who perform those service. I understand that TPCG may contact the health care professional who has completed the Professional Verification attached to this application, in order to confirm this information.

_________________________________________  __________
Applicant Signature                          Date

________________________
Person completing form if other than applicant (please check one):

☒ I certify that the information provided in this application is true and correct based upon information given to me by the applicant.

☒ I certify that the information provided in this application is true and correct based upon my own knowledge of the applicant’s health condition or disability.

Exceptions or Additions:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Last Name  First Name  Initial

_________________________________________  ___________________________  ______
Address                                             City                    Zip

Date:

_____ / _____ / ______

Daytime Phone  Evening Phone

_________________________________________

Relationship to Applicant

________________________________________________________________________
SECTION 6. Professional Verification

NOTE: This portion of the TPCG Paratransit Eligibility Certification Application must be completed by one of the following currently licensed professionals: Registered Nurse, Physician, Social Worker, Psychologist, Physical Therapist, Chiropractor, Occupational Therapist, Speech Pathologist, Nurse Practitioner, Physician’s Assistant, Mental Health Counselor, Respiratory Therapist, Vocational Rehabilitation Counselor, or Recreation Therapist employed by a medical facility.

The Americans with Disabilities Act of 1990 (ADA) is a civil rights bill which bans discrimination against people with disabilities. To meet their needs, public bus systems must provide a variety of services.

The applicant may be found eligible for paratransit van service for all trips he/she request, or eligible (based on functional ability) for some trips requests but not for others, or capable of using the regular bus.

NOTE: All TPCG buses are Low-floor vehicles which eliminate steps to enter a bus, and feature ramps for wheelchairs.

The information you provide will enable us to make an appropriate determination for each trip request. All information will be kept confidential. Thank you for your assistance.

Capacity in which you know the applicant:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

What is the diagnosis of the applicant’s disability? Please describe specifically as possible in layman’s terms:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Does the applicant’s condition prevent him/her from using a low-floor ramp equipped bus?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Is this condition temporary?

O  No  O  Yes, for _____ months
I have reviewed all of the information contained in this application, and hereby certify that all information is true and correct to the best of my knowledge and ability.

Exceptions or Additions:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Print Name and Title

________________________________________________________________________

Signature

________________________________________________________________________

Clinic / Agency

________________________________________________________________________

Address                    City                    Zip

________________________________________________________________________

Date:       Phone

___/___/___  (   )

Professional License, Registration or Certification Number:

________________________________________________________________________