WARNER ROBINS TRANSIT LLC (WRT) PARATRANSIT SERVICE

Thank you for your interest in the WRT Paratransit service.

Residents of the WRT service area who are disabled in a way that affects their ability to travel are eligible for paratransit bus service. This program has nothing to do with a disabled person's income. The fact that their disability limits their ability to earn income has nothing to do with eligibility for the paratransit program.

In order for your application to be processed, all parts of the application must be filled out completely by the applicant and/or personal care attendant as well as the applicants' Licensed Healthcare Professional. A Healthcare Professional may include, but is not limited to a certified physician or nurse, vocational rehabilitation counselor, mental health counselor, mobility specialist, or social worker. If something does not apply to you please use" none" or" N/A" for non-applicable. Signatures are also required.

The information obtained in the certification process will be used only by WRT Paratransit Service to determine eligibility for transit services, will be kept confidential, and will not be provided to any other person or agency. If an application is incomplete, it will be returned to the applicant with an explanation of the missing information.

WRT will determine eligibility within 21 days of receipt of the completed application and professional verification by the Healthcare Professional.

You will be notified when your application is approved, an appointment scheduled for a photo ID card, and provided with materials explaining the rules and regulations governing the service. Eligibility may be granted for a period of 6 months to 3 years, depending on your disability transportation needs.

If your application is not approved, WRT will send a statement describing your ineligibility and how to appeal.

If you have any questions completing this application please call Spring Rosati, WRT Manager at (478) 225-6982.

On the following pages you will find:

Categories of Eligibility for Paratransit Service

The Americans with Disabilities Act of 1990 (ADA) is a civil rights bill that prohibits discrimination against people with disabilities. The intent of ADA is to ensure that persons with specific disabilities have equal access to public transportation. In accordance with ADA, WRT provides a variety of services, including paratransit service. Paratransit service is a specialized service providing a curb-to-curb shared ride for eligible individuals with disabilities who are unable to use the regular fixed route bus service.

WRT is required to determine the eligibility for paratransit service for individual applicants. Categories of eligibility for paratransit are as follows:

A. The applicant has a specific impairment-related condition(s) which prevents the applicant from traveling to or from WRT Bus Stops.

B. The applicant needs assistance of a wheelchair lift or other boarding assistance devices and is able, with such assistance to get on, ide, and get off vehicles which are accessible to and usable by individuals with disabilities.

C. The applicant is unable, as the result of a physical/ visual/ mental impairment, and without the assistance of another individual (except the operator of a wheelchair lift or other boarding assistance device), to get on, ride or get off vehicles on the WRT system which are accessible and usable by individuals with disabilities.

If you believe your disability may fit into one of the categories described above, you must apply for certification by completing the attached Paratransit Application. In addition, a licensed professional (i.e., physician or physical therapist) must verify your eligibility application.

Instructions and Checklist for Paratransit Application

Before mailing the paratransit application form, please complete the following checklist:

1. Did you review the application carefully?
2. Did you review the eligibility requirements on the previous page (2) carefully?
3. Did you fill out the form completely (pages 4 and 5), answering all of the questions on the Application? Remember that any incomplete form will be returned without being processed.
4. Have you signed and dated the Application?
5. If applicable, has the person who assisted you signed and dated the Application (bottom of page 5)?
6. Has a licensed professional completed all questions pertaining to the Healthcare Professional Verification portion of the Application (pages 6-7)?
7. If you have completed all the items on the checklist, please return the completed application to:

Warner Robins Transit LLC

1109 Russell Parkway, Suite B2

Warner Robins, GA 31088

Warner Robins Transit LLC – Application for Paratransit Service Eligibility

Applicant's Information:
(To be completed by Applicant)

Last Name: _____ First: _____ MI: _____

Work Phone: (____) -_____ Home Phone: (____) -_____ Male: __Female: ____

Date of Birth: _____ Age: _____ Social Security No.: _____

Permanent Residence:

Street Address: _____ Apt. No.: _____

City: _____ County: _____

State: _____ Zip: _____

Mailing Address (if different from Permanent Residence):

Address: _____

City: _____ County: _____

State: _____ Zip: _____

Can you get on and off of a bus/van that does not have a passenger lift? ____Yes ____No

Are you able to provide your address and phone number upon request? ____Yes ____No

Are you able to recognize a destination or landmark? ____Yes ____No

Do you use any of the following mobility aids or specialized equipment?

Check all that apply.

[ ] Cane [ ] Power Scooter (3-wheeler)

[ ] Walker [ ] Power Chair (size _____) (weight _____) [ ] Other: _____

[ ] Crutches [ ] Large Power Chair (size ___) (weight ____)

[ ] Leg Braces [ ] Service Animal

Person to contact in case of emergency:

Name: _____ Relationship: _____

Street Address: _____ Apt. No.: _____

City: _____ State: _____ Zip:

_____

Work Phone: _____ Home Phone: _____

I certify that all of the information that I have given in this application is true and accurate to my knowledge. I understand that falsifying my application will result in denial of services.

I understand that all information will be kept confidential and only the information required to provide the services will be disclosed to those who perform the services.

I understand that WRT Paratransit will contact my healthcare professional to confirm information.

I authorize my healthcare professional to release any and all information required by WRT Paratransit to determine my eligibility.

Print Full Name: _____ Signature:_____

Date: _____

***If you are not the applicant but are completing the application on the applicant's behalf, you must provide the following information: (Please Print)**

Name: _____

Address: _____

City: _____ County: _____

State: _____ Zip: _____

Day Phone: _____Cell Phone: _____

Relationship to Applicant: _____

Signature: _____

Warner Robins Transit LLC- Request for Healthcare Professional Verification

(To be completed by License Healthcare Professional)

Please complete and sign the form below to provide information regarding applicant's disability and its impact upon his/her ability to utilize our transit services. The information that you provide will assist Warner Robins Transit /Paratransit Division in determining whether or not the applicant is eligible for our services.

To qualify the applicant must have a disability that prevents him/her from using fixed route transit service.

Explain HOW the applicant's disability or health related condition prevents the application from independently using the fixed route transit service.

_____

_____

_____

_____

Thank you for your cooperation in this matter.

I certify that _____ who currently resides at _____ is a disabled person due to the following criteria(s):

[Identify all applicable criteria(s).]

1. Non-Ambulatory Disabilities: Impairments that, regardless of cause or manifestation, for all practical purpose confine individuals to wheelchairs.
   *Specify Specific Disability:*_____

2. Semi-Ambulatory Disabilities: Impairments that cause individuals to walk with difficulty or insecurity. Individuals using braces or crutches, amputees, and those with arthritic, neuromuscular, pulmonary, or cardiac disorders may be semi-ambulatory.
   Specify Specific Disability: _____

3. Sight Disabilities: Total blindness or incorrect impairment affecting sight to the extent that the individual functioning in public areas is insecure or exposed to danger.
   Specify Specific Disability: _____

4. Hearing Disabilities: Total deafness or uncorrectable hearing handicaps that might make an individual insecure in public areas because he/she is unable to communicate or hear warning signals.
   Specify Specific Disability: _____

5. Disabilities of Incoordination: Faulty coordination palsy from brain, spinal, or perinea nerve injury.
   Specify Specific Disability: _____

6. Mental Disorder: Applicant is unable to perform routine repetitive tasks or has physical or other mental impairment resulting in restriction of function and cannot become licensed to operate a vehicle.
   *Specify Specific Disability:*_____

7. Brain Damage: Diagnosis by a psychiatrist, neurologist, or clinical pathologist establishing that the applicant has organic brain syndrome.
   *Specify Specific Disability:*_____

8. Other:
   Specify Specific Disability: _____

Is the applicant's condition temporary? ____Yes ____No

If yes, expected duration is _____months

Does the applicant require a Personal Care Attendant for travel? ____Yes ____No

Does applicant use mobility aids? ____Yes ____No

If yes, what type? _____

Healthcare Professional Name: _____

Office Street Address: _____

City: _____State: _____ Zip: _____

Office Phone: _____ Professional License No.: _____

Signature: _____ Date: _____

Pease check the one that applies to you: ___ Physician ___ Vocational Rehabilitation Counselor
___ Social Worker __ Other

***Applicant should Mail completed application and Request for Healthcare Professional Verification to**:

Warner Robins Transit LLC
1109 Russell Parkway, Suite B2
Warner Robins, Georgia 31088