Dear Applicants:

Thank you for your interest in S.M.A.R.T. Paratransit Service. Access is a curb-to-curb demand response service provided to disabled and elderly citizens. The enclosed application will determine your eligibility to use Paratransit service.

S.M.A.R.T. Paratransit is an ADA paratransit service, required by Federal Law, which S.M.A.R.T. elects to provide for disabled residents. ADA service eligibility and certification is required in order to use the service.

The enclosed application must be filled out completely and legibly. The enclosed Physician Verification of Disability Form must be completed by a doctor, licensed health care provider, or licensed rehab/social worker familiar with your disability.

Once S.M.A.R.T. receives your completed application, you may be contacted to schedule an in-person interview to aid in the determination of your eligibility. Upon request, transportation will be provided to you free of charge both to and from the interview site.

You will receive a determination letter within 21 days. If you require assistance in completing this application, you may call our office at (662) 325-7594 or (662) 325-5204.

Again, we thank you for your interest in S.M.A.R.T. Paratransit Service.

P.O. Box 6350 Mississippi State, MS. 39762 P: 662-325-5204 F: 662-325-3605

CERTIFICATION OF ELIGIBILITY

Return completed application to:
S.M.A.R.T.
Paratransit Application
P.O. Box 6350
Mississippi State, MS 39762

PART 1 ***General information to be completed by applicant***

Last Name	First Name	Middle

Street Address	Apt. #

City	State	Zip Code

If this is a gated community, please provide gate code: _____

Home Phone	Work Phone	Cell Phone

Date of Birth

In Case of Emergency Notify:

Name	Relationship

Home Phone	Work Phone	Cell Phone

Address	City	State	Zip Code

Part 2 ***Information on disability and mobility equipment***

How does your disability prevent you from using the S.M.A.R.T. fixed-route service?

Is your disability permanent? Yes No

If not, expected duration of your disability? _____

Have you ever had a seizure? Yes No

If yes, what type? _____ How often? _____

Are your seizures controlled with medication? Yes No

Do you use any of the following mobility aids? *(Circle all that apply)*

Manual Wheelchair	Walker	Service Animal
Powered Wheelchair	Cane	Portable Oxygen
Powered Scooter	Braces	Crutches
Prosthesis	Other _____	

Part 3 ***Questions on using S.M.A.R.T. fixed route service***

1. Have you ever used S.M.A.R.T.'s fixed-route service? Yes No
2. Are you able to travel to the nearest bus stop? Yes No

If no, please explain:

3. Are you able to use railings or handles? Yes No
4. Are you able to keep balance while seated on a moving bus? Yes No
5. Are you able to understand bus schedules? Yes No

   Understand and follow directions? Yes No

   Process Information to ride S.M.A.R.T.? Yes No

6. Are you prevented from traveling to or from a bus stop boarding location for one or more of the following reasons? *(Circle all that apply)*

Inability to negotiate hilly terrain	Extreme sensitivity to climate change
Allergic/Environmental sensitivities	Hyper-fatigue, frailty
Night blindness	Inability to cross busy intersections
Inability to climb three 10-inch steps	Bus stop too far away

7. Are you able to perform the following functions without supervision?
   a) Find your way between familiar locations?

      Yes Yes, with training No

   b) Signal the bus driver to get off at a familiar stop and get off the bus there?

      Yes Yes, with training No

   c) At a bus stop served by more than one bus route, can you distinguish the correct bus to board and indicate your intention to board?

      Yes Yes, with training No

8. Are you able to perform the following functions with the assistance of another person?

Travel 200 feet (the length of a city block)	Yes	No
Travel ¼ mile (the length of three city blocks)	Yes	No

9. Is your ability to get from place to place affected by: *(Mark all that apply)*

   _____ Terrain, such as steep hills, no sidewalks/crosswalks, or other conditions

   _____ Rain, snow, ice

   _____ Extreme temperatures of heat or cold

10. Are you able to wait outside for 10 minutes?

    Yes No

11. Do you have trouble standing for more than 15 minutes?

    Yes No

12. Are you able to cross the street of a busy intersection by yourself?

    Yes No

13. If travel training were available, would you be interested in participating?

    Yes No

14. Please read the following statements and check those which best describe what you believe is your ability to use S.M.A.R.T. bus without assistance. You may select more than one.

_____ I use S.M.A.R.T. bus service frequently.

_____ I can use the S.M.A.R.T. for some trips, but not at other times because there are barriers that prevent me from using the system.

_____ I have difficulty understanding and remembering all the things that I would have to do to find my way to and from the bus.

_____ I believe I could learn to ride the bus if someone taught me.

_____ I have a visual disability, which prevents me from getting to and from the bus, even with training.

_____ The severity of my disability can change from day to day. I can ride the bus only when I am feeling well.

_____ I can get to and from the bus if the distance is not too great, and the route is barrier-free.

_____ I can never use the bus by myself.

_____ I am not able to use the S.M.A.R.T. bus for other reasons. *(Please explain)*:

15. List three of your most frequent destinations, and how you get there now?

Destination	Frequency of Travel	How do you get there now?
_____	_____	_____
_____	_____	_____
_____	_____	_____

PART 4 ***Please initial all the following statements indicating you have read and understand each statement.***

I understand my rights and responsibilities for Paratransit service, and they are:

_____ 1. S.M.A.R.T. paratransit service is public transportation and I will be sharing rides with other passengers.

_____ 2. S.M.A.R.T. paratransit does not provide emergency service.

_____ 3. Four *"No Shows"* in 30 days could result in suspension of service.

_____ 4. S.M.A.R.T. operators may arrive 15 minutes before or 15 minutes after the scheduled pick-up time.

_____ 5. The S.M.A.R.T. driver/operators will ***ONLY*** wait 5 minutes from the time they arrive.

_____ 6. Wheelchair lifts can accommodate up to 800 lbs., and 30 inches in width. I understand the combined weight of me, my wheelchair, and any accessories must weigh less than 800 lbs. I also understand the width of my wheelchair cannot exceed 30 inches.

_____ 7. S.M.A.R.T. reserves the right to require a Personal Care Attendant (PCA) at the time of the pick-up. If I am required to have a PCA at the time of pick-up, and I do not have one, I will be unable to ride.

I certify the information provided in this application is accurate. I understand that false information may result in the denial or annulment of Paratransit service. I further understand that 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 services.

_____ _____

Applicant's Name Date

*** If someone else is completing this application and/or assisted the applicant, that person must complete the following:

_____ _____

Name Relationship to Applicant

_____ _____

Signature Date

Home Phone Cell Phone Work Phone

Starkville – Mississippi State University Area Rapid Transit

Paratransit Service

Physician Verification of Disability Form

**** PLEASE NOTE ****

This form must be filled out in its entirety. Incomplete forms will not be processed and will be returned to the patient.

_____ _____

Patient Name Date of Birth

The person named above is ☐ **currently being treated** or ☐ **was formerly treated** by me.

The person has informed me of his/her intent to apply for S.M.A.R.T. paratransit service. The information provided in this form is intended to verify any medical/health conditions that **prevent** the applicant from using the fixed-route shuttle service which is provided by S.M.A.R.T.

Please Check One: _____ Physician
_____ Licensed Health Care Provider
_____ Licensed Rehab/Social Worker

Medical diagnosis and explanation of condition causing disability:

_____
_____
_____
_____
_____
_____
_____

Disability Status (Select One):

_____ Patient will be temporarily disabled for _____ months.
_____ Patient is considered permanently disabled.

Does the disability prevent the applicant from utilizing the S.M.A.R.T. fixed route shuttle service (regular bus service)? If yes, please describe in detail.

_____
_____
_____
_____
_____

Is the applicant on dialysis?	Yes	No
Does the applicant have a hearing impairment?	Yes	No
Is the applicant able to:		
Walk or wheel ¼ mile (3 blocks) without the aid of another person?	Yes	No
Climb three 10-inch steps with assistance?	Yes	No
Wait outside without support for 15 minutes?	Yes	No
Recognize a destination or landmark?	Yes	No
Give addresses or phone numbers upon request?	Yes	No
Deal with unexpected situations or unexpected changes in routine?	Yes	No
Ask for, understand, and follow directions?	Yes	No
Safely and effectively travel alone through crowded and/or complex facilities?	Yes	No

The vehicle wheelchair lift will accommodate up to 800lbs. and 30 inches in width. **The applicant's weight is _____lbs.**

Mobility device Make and Model: _____

Based upon my professional knowledge of the applicant/ I certify that the preceding information is true and correct.

Name (Please Print) Office Phone Number

Office Street Address City, State Zip Code

State License Number (Complete if Applicable – Must be Current)

_____ _____

Signature Date