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

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle</th>
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<tr>
<th>Street Address</th>
<th>Apt. #</th>
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If this is a gated community, please provide gate code: _______________________________________

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<tr>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Cell Phone</th>
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Date of Birth

In Case of Emergency Notify:

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<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
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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)

<table>
<thead>
<tr>
<th>Manual Wheelchair</th>
<th>Walker</th>
<th>Service Animal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Powered Wheelchair</td>
<td>Cane</td>
<td>Portable Oxygen</td>
</tr>
<tr>
<td>Powered Scooter</td>
<td>Braces</td>
<td>Crutches</td>
</tr>
<tr>
<td>Prosthesis</td>
<td>Other</td>
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</tbody>
</table>

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?

<table>
<thead>
<tr>
<th>Destination</th>
<th>Frequency of Travel</th>
<th>How do you get there now?</th>
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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.

_________________________________________ __________________________
_________________________________________ __________________________
_________________________________________ __________________________
_________________________________________ __________________________
_________________________________________ __________________________
_________________________________________ __________________________
_________________________________________ __________________________

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.

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<tr>
<th>Name (Please Print)</th>
<th>Office Phone Number</th>
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<table>
<thead>
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<th>Office Street Address</th>
<th>City, State</th>
<th>Zip Code</th>
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<thead>
<tr>
<th>State License Number (Complete if Applicable – Must be Current)</th>
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<table>
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