

APPLICATION FOR MITS

Please return to:

The T (MITS) - 1600 E. Lancaster Ave. - Fort Worth, Texas 76102

(817) 332-4444 VOICE

(817) 215-8934 FAX

For Office Use Only

Date Received _____

I.D.# _____

Status Code _____

PCA _____

Mapsco Grid _____

SECTION 1

To be completed by applicant _ Please type or print

Have you ever been certified to use MITS? YES NO Date of Birth _____

If no, have you ever applied for MITS? YES give date _____

1. Name: Mr Ms _____
First Initial Last

2. Home Phone _____ WorkPhone _____

3. Home Address _____
Street or Box # City State Zip

Apartment Name & Number _____

Mailing address _____
(If different) Street or Box # City State Zip

4. Language Preference: English Spanish Braille Large Print
AUDIO English/Spanish (circle one)

5. Emergency Contact _____
Name Relationship Daytime Phone

Address _____ City _____ State _____ Zip _____

6. Assistive device used? Check all that apply:

Manual wheelchair Electric wheelchair Powered scooter Portable Oxygen

Cane Crutches Walker Prosthesis Mobility/White Cane

Service Animal What service does animal provide? _____

7. If you use a wheelchair or scooter, does your residence have a wheelchair ramp? Yes No

If **No** ramp, how many steps? _____ (Driver will not take a wheelchair up or down a step higher than 6" or more than one step.)

If more than one step, how do you transport your wheelchair to street level? _____

8. If necessary, can you transfer yourself from a wheelchair to a passenger car? Yes No

9. Have you ever used the city bus service? Yes No Have you ever had training to use the city bus service? Yes No

Most frequent destinations- list addresses _____

Applicant Signature _____

Date _____

(Note: Once we have received a completed application with all required information, it may take up to 21 days to process it.)

SECTION 2: Applicant Name _____ [for fax transmissions]

Date of Birth _____ / _____ / _____
(required) Mo / Day / Yr

For Office Use Only
NBR _____

Must be completed by Agency or Physician - Please type or print

Please remember that the paratransit program is a subsidized shared ride service that provides transportation to persons who have a disability that **PREVENTS** use of the existing public transit. Also keep in mind that we have a high volume of individuals who are interested in service, but the purpose of paratransit is **for those qualified persons whose only option for transportation is paratransit**. If you have questions regarding eligibility, please call the MITS office at 332-4444. All final decisions regarding eligibility are made by the MITS administrative staff.

10. What is the medical diagnosis that causes the disability?

(i.e., if mental retardation - list I.Q., seizures -list type, # per month)

Date of diagnosis _____

11. How does the disability prevent the applicant from riding regular city bus service? What are their functional limitations?

List any medications that may impair or aid with mobility. _____

Is there any therapy pending? _____ Expected results _____

If the person has a disability affecting mobility: Is the person: [check appropriate box(s)]

Able to **walk or wheel self** without assistance? Yes No (3 blocks = 1/4 mile)
less than 1 Block 1 Block 3 Blocks 6 Blocks 9 Blocks

Remarks _____

Using a handrail, is applicant able to climb three 12 inch steps without assistance? Yes No

Remarks _____

Able to wait outside in all weather conditions without support for at least 20 minutes? Yes No

Remarks _____

If vision impaired, what is **Best Corrected Acuity** (Snellen)?

Right eye _____ Left eye _____ **Field Restriction:** Right _____ Left _____

12. Does this person use any assistive devices? If so, what? _____

Has this person ever had training to use the city bus service? Yes No Do Not Know
Could this person use regular city bus service? **never sometimes always** If wheelchair accessible? _____
Could this person benefit from Bus Route training? Yes No

13. Is disability Permanent Temporary

If temporary, how long will applicant need service? _____

14. All certified applicants are allowed to take a guest with them. Is the applicant required to have a personal care attendant to administer assistance with them? Yes No

If needed, applicant must provide their own attendant.

Agency or Physician Name, Address, and Telephone

Verifying Agency or Physician Name () Area Code Phone / Fax #

Address City State Zip

15. I (PRINT NAME) _____ certify that the above information is true and correct.

Signature of Verifying Agency or Physician _____ Date _____

Any additional information, please attach. Thank you for taking the time to complete this application.