PARATRANSIT APPLICATION

For Office Use Only

Return application to:
EZ-Rider
P.O Box 60808
Midland, TX. 79711
(432) 561-9990 Office
(432) 561-8056 Fax

I.D. #_____
EE Initials_____

SECTION I
Completed by Applicant **Male or Female**

Social Security #_____

Have you ever been certified by EZ-Rider? Yes ☐ No ☐ Date of Birth_____/_____/_____

Have you ever applied for this service at EZ-Rider? Yes ☐ No ☐ Give date_____

1. Name_____
First Initial Last

2. Home Phone_____ Work Phone_____

3. Home Address_____
Street or Box City State Zip

Mailing Address_____
(If different) Street or Box City State Zip

4. Language Preference English ☐ Spanish ☐ Other ☐_____

Communication Preference Phone ☐ Email ☐

5. Emergency Contact_____
Name Relationship Phone #

Address_____
Street or Box City State Zip

6. Assistive device used? Check all that apply:

Manual Wheelchair ☐ Electric Wheelchair ☐ Powered Scooter ☐ Walker ☐

Crutches ☐ Portable Oxygen ☐ Cane ☐ 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 needed applicant must provide their own Personal care attendant.***

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 ☐

What are you most frequent destinations? List addresses_____

_____

_____

Applicant Signature_____ Date_____

(Note: Once the completed application is received with all required information, processing could take up to 21 days.)

SECTION II
Completed by Physician

Applicant Name_____ (for fax transmissions)

Date of Birth_____/_____/_____

Must be completed by Physician – Please type or print
Please remember than 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 EZ-Rider office at 432-275-0495 or 265-0498. All final decisions regarding eligibility are made by the administrative staff at EZ-Rider.

10. **What is the medical diagnosis that causes the disability?**
(i.e., if mental retardation – list IQ, if 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 (es)]

Able to **walk or wheel self** without assistance? Yes ☐ No ☐ (3 blocks = ¼ mile)

Less than 1 Block ☐ 1 Block ☐ 3 Blocks ☐ 6 Blocks ☐ 9 Blocks ☐

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 ☐ Don't 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.***

Physician Information

_____(_____)_____/_____
Verifying 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 Physician _____ Date _____

Please attach any additional information. Thank you for taking the time to complete this application.

EZ-RIDER
MIDLAND ODESSA URBAN TRANSIT DISTRICT; PO BOX 60808; MIDLAND, TEXAS 79711; TEL: (432) 561-9990 FAX: (432) 561-8056

EZ-Rider ADA Paratransit Services Rules of Ridership

Reservations are made within a one-hour window of the intended drop-off or pick-up. It is the responsibility of the client to be ready for pick-up any time within that window.

Reservations are accepted from 8:00 a.m. to 5:00 p.m. Monday through Friday. Reservations must be made no later than 5:00 p.m. one day in advance. Monday trips should be scheduled on Friday; reservation requests left on the EZ-Rider voicemail system over the weekend may be accommodated subject to availability.

Cancelations must be made at least (1) hour in advance. Failure to cancel at least (1) hour in advance will be counted as a "No Show."

The driver shall only wait 5 minutes after (s)he arrives to pick up a client. After 5 minutes, the driver must mark the trip as a "No Show" and continue to his/her next stop.

Accumulation of multiple "No Shows" will result in action outlined in the EZ-Rider No Show and Late Cancelation Policy.

It is the responsibility of the client to advise EZ-Rider if a trip was missed for reasons beyond the client's control.

Clients must present full fare or a pre-purchased ticket when boarding. When paying with cash, clients should have the exact fare amount. Drivers do not make change.

A client may be accompanied by a maximum or (1) companion and (1) Personal Care Attendant (PCA). There is no fare charged for the PCA to accompany the client on paratransit trips; a companion must pay the regular fare.

PCAs are responsible for assisting clients with all personal needs.

Items brought on the bus are limited to what the client can carry aboard without making additional trips.

Back-to-back trips must be scheduled at least (30) minutes apart.

Eating, drinking, and smoking on the bus are prohibited at all times.

Client Statement

I have read and understand the above stated rules for use of ADA Complementary Paratransit Services.

Printed Name: _____

Signature: _____

Date: _____