



Eligibility Application for Complimentary ADA Paratransit Services

OFFICE USE ONLY	
Date Received	_____
Date Processed	_____
Date Approved	_____
Date Denied	_____
Date Notified	_____
Status Code	_____

1. **ADA Category 1:** A person who is unable to board, ride, or exit any vehicle independently on the fixed route system that is readily accessible to and usable by persons with disabilities.
2. **ADA Category 2:** A person who needs the assistance of a wheelchair lift and one is not available on the fixed route service during the time the individual wishes to travel. (All Rover fixed route vehicles are fully accessible).
3. **ADA Category 3:** A person who has an impairment-related condition that prevents getting to or leaving a bus stop.
4. If all spaces are not completed this form will be returned.
5. Please read the entire application and print neatly or type; only one person per application.
This application is available in accessible format. If you have any questions regarding this application or need assistance completing the form, please call (615) 801-3039, or TDD (615) 849-2689.

<u>Section 1—Personal Information</u>	
Date of Application:	_____
Name (Please Print):	_____
Address:	_____
City:	_____ State: _____ Zip: _____
Home Telephone:	_____ Work/Cell Telephone: _____
Birth Date:	_____ Email Address: _____
Emergency Contact (Application will be returned if left blank.)	
Name: (Please Print):	_____
Address:	_____
Home Telephone:	_____ Work/Cell Telephone: _____
Relationship:	_____
<i>I certify that information provided in this application is true, authorize the health care professional certifying this application to release information about my disability to ROVER and Mid-Cumberland Human Resource Services</i>	
Applicant's Signature:	_____
If this application has been completed by someone other than the person requesting reduced-fare eligibility, that person MUST FULLY COMPLETE the following:	
Name of Individual or Agency:	_____
Address:	_____
(City / State / Zip):	_____
Phone: Fax Number:	_____
Signed:	_____ Date: _____

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Section 2—Disability Information

1. Please describe your impairment and/or illness and check any applicable items below (examples include blindness, multiple sclerosis, heart condition): _____

- a. Visually Impaired: Total _____ Partial _____ Vision: Right 20/____ Left 20/ _____
b. Hearing Impaired: _____
c. Mentally or Developmentally Impaired: _____
d. Mobility Device: Powered _____ Manual _____ Scooter _____
e. Crutches: Braces _____ Walker _____ Prosthesis _____ Other _____
f. Other Mobility Limitations or Physical Impairments (please describe): _____

2. Do you require someone to assist you when you travel using transit? (It is a disabled rider's responsibility to provide a personal care attendant and a properly functioning mobility device. No fare is charged for a personal care attendant riding with a disabled rider.)
(Do not leave blank) YES _____ NO _____

3. Do you use any of the following aids? (Check all that apply)

_____ Wheelchair; if Your Wheelchair Is Larger Than a Common Wheelchair (30 Inches Wide; 48 Inches Long ; more than 600 lbs. when occupied), please describe it: _____

_____ Powered Scooter. If you use a scooter, will you be able to transfer to a seat? Yes _____ No _____
_____ Service Animal _____ Alphabet Board _____ Oxygen Tank
_____ Other Assistive Devices. If yes, please describe: _____

Section 3—Health Care Professional Certification

This certification must be completed by a licensed or certified health care professional , and received by Rover within 60 days of the health care professional's signature. Information will remain on file with Rover and is not subject to public review.

Name of Health Care Professional: _____
License Number/State Issued: _____ Phone: _____
Address: _____
City, State, Zip: _____

Check One: _____ Physician: (Specialty) _____
_____ Physician's Assistant _____ Nurse Practitioner _____ Audiologist _____ Podiatrist
_____ Optometrist _____ Licensed Clinical Psychologist _____ Certified School Psychologist
_____ Licensed Occupational Therapist _____ Licensed Physical Therapist

Expected duration of applicant's disability:
_____ Temporary: Short Term conditions likely to improve within one year
_____ Long-Term: Condition with potential for improvement or log periods of remission
_____ Permanent: Conditions with absolutely no expectation of improvement

I certify that the applicant is affected by the impairment/illness described, and as a result, requires the assistive devices described, and is unable to use mass transportation services as effectively as persons who are not so affected.

Signature: _____ Date: _____

Please Return Application to:

ROVER Eligibility Coordinator
4765 Florence Road
Murfreesboro, TN 37129