





## Section 2

Applicant Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Required) Month Day Year

### 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 CATS on Demand office at (225) 389-8920 ext 325. All final decisions regarding eligibility are made by the CATS on Demand administrative staff.

1. What is the medical diagnosis that causes the disability? (i.e., if mental retardation, list I.Q.; if seizures, list type and # per month) \_\_\_\_\_

Date of diagnosis? \_\_\_\_\_

2. 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 or boxes) 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 \_\_\_\_\_

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 \_\_\_\_\_

3. 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 travel training? Yes  No

4. Is disability: Permanent  Temporary

If temporary, how long will applicant need service? \_\_\_\_\_

5. All certified applicants are allowed to take a guest with them. Is the applicant required to have a personal care attendant to administer assistance? 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 # Area Code FAX #

\_\_\_\_\_  
Address City State Zip

6. 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.**