GULF COAST TRANSIT DISTRICT PARATRANSIT SERVICE APPLICATION

Please complete this application thoroughly and to the best of your ability. If there are questions you do not understand, call GCTD at (800) 266-2320 for assistance before returning this form. In order to be considered complete, every question on the application must be answered.

The purpose of the application is to provide an opportunity for you to describe the limitations you may have which prevent you from using GCTD fixed route bus service. The more information you provide, the better GCTD will understand your ability.

It is the responsibility of the individual to have their certifying healthcare professional fill out the last page of this form as well as write a letter on letterhead, confirming disabilities.

(All information is confidential)

BASIC INFORMATION

Name: First, Middle Initial, Last Name (Mr./Mrs./Ms)						
Date of Birth						
Phone Number	Home					
	Cell Work					
	Social Security					
Address						
	City		State		Zip	

EMERGENCY CONTACT INFORMATION

Name						
Relationship to applicant						
Phone Number	Home					
	Cell					
	Work					
Address						
	City		State		Zip	

YOUR OPINION ON BUS SERVICE

Read the following statements and circle the one that best describes what you believe is your ability to use GCTD fixed-route bus service by yourself.

Circle only one:

1. I don't think I can ever ride the bus independently.
2. I'm really not sure if I can ride the bus.
3. I can ride the bus by myself sometimes, if the conditions are right.
4. I use the bus frequently.

We would like to understand your reasons for using GCTD Paratransit service instead of the fixed-route bus service. Read the following statements and circle the letter that best describes how important each of these factors is to your decision.

A = Very Important	B = Not Important	C = Not Sure

Fear of crime	A	B	C
What the weather is like	A	B	C
Whether I have packages to carry	A	B	C
Getting on and off the bus	A	B	C
Getting to and from the bus stop	A	B	C
Other:	A	B	C
Other:	A	B	C

Indicate the one factor above which is most important to your decision.

_____

ABOUT YOU

Tell us about your disability.			
Is it a temporary condition?	Yes	No	Don't know
	If so, for how long?		

Do you use any of the following aids for mobility? (Circle all that apply)			
Manual Wheelchair	Electric Wheelchair	Power Scooter	Crutches/Walker
Cane	Service Animal	Personal Care Attendant	Other:

If you use a scooter or wheelchair, what is the scooter or wheelchair's:			
Width		Length	
Make		Weight	

Are you able to operate the aid on your own?	Yes	No

INFORMATION ABOUT YOUR CURRENT GCTD USE

Do you currently use GCTD fixed-route bus service at all?	YES			NO
When was the last time you used the GCTD fixed-route service?				
Where is the closest bus stop to your residence?				
Can you get to this stop by yourself?	Yes	No	Sometimes	Don't Know
If not, why not?				

YOUR FUNCTIONAL ABILITY

Your answers to the questions in this section will help us better understand your functional ability in specific areas. For each question, circle one answer. Your answer should be based on how you feel most of the time, under normal circumstances, and whether you can perform this activity independently.

Can you climb up and down three, 12 inch steps?	Always	Sometimes	Never	Don't Know
Use the telephone to get information?	Always	Sometimes	Never	Don't Know
Walk a city block in favorable weather?	Always	Sometimes	Never	Don't Know
If you are able to do this, how long does it take you?	0-5 mins	5-10 mins	10+ mins	Don't Know
Cross the street if there are curb cuts?	Always	Sometimes	Never	Don't Know
Ride up and down a wheelchair lift?	Always	Sometimes	Never	Don't Know
Walk 6 blocks in favorable weather?	Always	Sometimes	Never	Don't Know
If you are able to do this how long does it take you?	0-10 mins	10-20 mins	20+ mins	Don't Know
Wait up to 20 minutes at a bus stop that does not have a seat or shelter?	Always	Sometimes	Never	Don't Know
Travel up or down a gradual hill?	Always	Sometimes	Never	Don't Know
Find your own way to a bus stop, if shown the way once?	Always	Sometimes	Never	Don't Know
Travel by yourself?	Always	Sometimes	Never	Don't Know

If you need the assistance of another person, what do they do for you?			
Barriers in your surroundings that make it difficult to travel the fixed route?	Lack of curb cuts	Lack of sidewalks	Hills or other terrain
	Busy crosswalks	Poor sidewalk condition	Other
If other, explain			

WEATHER AND ENVIRONMENT CONSIDERATIONS

The following questions deal with how environmental factors impact your ability to use fixed-route or paratransit services.

Does the weather affect your ability to use the fixed-route service?	Always	Sometimes	Never	Don't Know
Explain				
How many steps are there at the entrance of your residence?				
Can you get to the Paratransit vehicle without the assistance of another individual?			Yes	No
If no, why not?				
Please describe the terrain near your residence.				
Are there sidewalks in your neighborhood?		Yes	No	

YOUR CURRENT TRAVEL

List your three most frequent destinations and how you get there now.

Destination	How Often	How do you travel there

ADDITIONAL INFORMATION

Use this space to tell us anything else you would like us to know about your travel challenges and your ability to use fixed-route services.

Did you require any assistance to complete this form?	Yes	No
If yes, how did he/she assist you?		

I hereby certify that the above information is correct.	
Signature of Applicant	
Date	
Name	
Relationship	
Phone Number	
Address	

FOR OFFICE USE ONLY			
Date Received		Date Approved	

GCTD PERMISSION FOR RELEASE OF INFORMATION

This gives GCTD permission to ask your healthcare professional for information about your disability.

In order to allow GCTD Paratransit Service to evaluate your request, it may be necessary to contact a healthcare professional to confirm the information that you provided. Identify the healthcare professional best able to verify your functional ability to use transit service. Identify the physical or other official that would have the appropriate specialization to provide more information about your condition. GCTD will not use any information in this application except for the purposes of determining eligibility.

Please circle one of the following to best describe your healthcare professional		
Rehabilitation Counselor	Social Service Professional	Independent Living Counselor
Occupational Therapist	Physician	Other Healthcare Professional

Professional's Name						
Phone Number						
Address						
	City		ST		ZIP	

The above healthcare professional is familiar with my disability and is authorized to provide information to GCTD as required to complete this application.

Signature of Applicant	
Date	

Please send completed Paratransit Service Application to:

Gulf Coast Transit District
1415 33rd St. N.
Texas City, Texas 77590

Or by email to:
customerservice@gulfcoasttransitdistrict.com

GCTD PARATRANSIT SERVICE

Please have your physician or healthcare professional fill out the below in full.

Dear Physician or Certified Healthcare Professional:

We are requesting your assistance so that we can determine whether the undersigned applicant is eligible for GCTD ADA Paratransit Services. Paratransit Service is an on-demand, origin-to-destination service for individuals whose disability prevents them from using the local fixed-route GCTD bus system because a passenger is:

**Unable, without the assistance of another person, to board, ride, or disembark from an accessible local GCTD bus. This includes people who, due to impairment, are unable to navigate the system.

**Prevented from getting to and from the bus stop, based on a disabling condition.

Please render judgment whether the applicant, in your professional opinion, can or cannot access an accessible bus due to a disability. We have provided the space below for you to describe in layman terms an applicant's disability and how it prevents use of the fixed route bus system. Detailed information will help GCTD make a proper eligibility determination.

Thank you,
Gulf Coast Transit District

IMPORTANT: PLEASE SIGN THE APPLICATION BELOW AND PROVIDE AN ADDITIONAL SIGNATURE ON YOUR PROFESSIONAL LETTERHEAD OR PRESCRIPTION NOTE TO HELP US PREVENT FRAUDULENT APPLICATIONS. THE APPLICATION CANNOT BE PROCESSED WITHOUT ALL REQUESTED INFORMATION AND BOTH SIGNATURES.

Patient/Client Name				
How does the medical condition prevent local fixed-route bus usage?				
Is this disability:	**Permanent**	**Temporary**	**If temporary, please specify how many months**	
Does the applicant use any of the following aids for mobility?				
Manual Wheelchair	**Electric Wheelchair**	**Cane**	**Guide/Service Animal**	**Other (please specify)**
Crutches	**Powered Scooter**	**Walker**	**Personal Care Attendant**	
Name		**Phone Number**		
Signature		**Date**		