



# Coast Transit Authority

333 Debuys Road, Gulfport, MS 39507 • 228/896-4010 • 228/896-8081 (facsimile)

## REQUEST FOR CERTIFICATION OF ADA PARATRANSIT ELIGIBILITY Customer Application

The information obtained in this certification process will only be used by Coast Transit Authority for the provision of transportation services. Information will only be shared with other transit providers to facilitate travel in those areas. The information will not be provided to any other person or agency.

1. Name: \_\_\_\_\_

2. Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

3. Telephone Number Home: \_\_\_\_\_ Work: \_\_\_\_\_

4. Date of Birth \_\_\_\_\_ Social Security #: \_\_\_\_\_

5. My race is (check all which apply):

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> African American/Black            | <input type="checkbox"/> Asian           | <input type="checkbox"/> Caucasian/White  |
| <input type="checkbox"/> Hispanic                          | <input type="checkbox"/> American Indian | <input type="checkbox"/> Pacific Islander |
| <input type="checkbox"/> Other (please be specific): _____ |  |   |

6. My primary language is (this would be language used to communicate, read, etc.)

\_\_\_\_\_

7. My individual yearly income is (check only one)

- |   |                                      |                                      |
|---|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> \$0-10,999     | <input type="checkbox"/> \$11-24,999 | <input type="checkbox"/> \$25-39,999 |
| <input type="checkbox"/> above \$40,000 | <input type="checkbox"/> No response |                                      |

8. What is the disability which prevents you from using our fixed-route service?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is this condition temporary?       Yes       No

If yes, expected duration until: \_\_\_\_\_

9. How does this disability prevent you from using fixed-route services? Please explain completely, using additional sheet if needed.

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10. Are there any other effects of your disability of which we need to be aware?

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THE FOLLOWING INFORMATION WILL BE USED TO ENSURE THAT AN APPROPRIATE VEHICLE IS UTILIZED TO PROVIDE YOUR TRANSPORTATION AND THAT AN ACCURATE ANALYSIS OF YOUR TRIP REQUESTS CAN BE MADE BY COAST TRANSIT AUTHORITY.

11. Do you use any of the following aids to mobility? (please check all that apply)

- Manual Wheelchair                       Electric Wheelchair                       Powered Scooter  
 Cane     Crutches     Guide Dog  
 Personal Care Attendant                       Other \_\_\_\_\_

12. Do you require a Personal Care Attendant when you travel using transit?

- Yes                       No                       Sometimes

13. Please answer the following questions:

	Yes	No	Sometimes
Can you travel 200 feet (less than a football field) without assistance of another person?			
Can you travel ¼ mile (length of a football field) without assistance of another person?			
Can you travel ¾ mile (length of three football fields) without assistance of another person?			
Can you climb three 12-inch steps without assistance of another person?			
Can you wait outside without support for ten minutes?			

14. I hereby certify that the information given above is correct.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

15. If this application has been completed by someone other than the person requesting certification, that person must complete the following:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Telephone Number: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

In order for Coast Transit Authority to evaluate your request, it may be necessary to contact a physician or other professional to confirm the information you have provided.

Please complete the following information and authorization form.

The following (check one)  Physician;  Health Care Professional;  Rehabilitation Professional is familiar with my disability and is authorized to provide Coast Transit Authority with the required information to complete this certification:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Telephone Number: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(please print)

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**Return completed form to:**

Coast Transit Authority  
333 DeBuys Road  
Gulfport, MS 39507

Phone: (228) 896-4010  
Fax: (228) 896-8081  
www.CoastTransit.com