



<b>FOR OFFICE USE ONLY</b>	
Date Received	_____
I.D. #	_____ Status _____
Expiration Date	_____

**APPLICATION FOR JETS ADA PARATRANSIT SERVICE**

**Please return to: JETS Mobility Manager  
PO Box 1845  
Jonesboro AR 72403  
870-935-5387 Office 870-933-5649 Fax**

# Section 1

**To be completed by applicant-Please type or print**

Have you ever been certified to use JETS Paratransit Services? Yes\_\_\_\_ No\_\_\_\_

If no, have you ever applied for JETS Paratransit services? Yes\_\_\_\_ Give Date\_\_\_\_\_

1. Name: Mr.\_\_\_\_ Ms.\_\_\_\_ Mrs. \_\_\_\_ \_\_\_\_\_

2. Home Phone: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

3. Home Address \_\_\_\_\_

4. Date of Birth \_\_\_\_\_

5. Emergency Contact

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

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

Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

6. Do you use any of the following mobility aids? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, check all that apply.

Manual Wheelchair\_\_\_\_\_ Electric Wheelchair\_\_\_\_\_ Powered Scooter\_\_\_\_\_

Cane\_\_\_\_\_ Service Animal\_\_\_\_\_ Crutches\_\_\_\_\_ Portable Oxygen\_\_\_\_\_

7. If you use a wheelchair or scooter, does your residence have a wheelchair ramp?

Yes\_\_\_\_\_ No\_\_\_\_\_ If no ramp, how do you transport your wheelchair to street level?

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**(Policy does not permit drivers to take wheelchair up or down a step to or from your residence or any other facility in our service area.)**

8. If necessary, can you transfer yourself from a wheelchair to a passenger seat?

Yes\_\_\_\_\_ No\_\_\_\_\_

9. Have you ever used the JETS Fixed Route bus service? Yes\_\_\_\_\_ No\_\_\_\_\_

10. Would you be interested in learning about using the Fixed Route services available to you at a discounted rate through Travel Training or Route Deviations?

Yes\_\_\_\_\_ No\_\_\_\_\_

11. Please list some of your most frequent destination addresses:

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Applicant Signature\_\_\_\_\_

Date\_\_\_\_\_

**(Note: Once we have received a completed application (Sections 1 and 2) with all required information, per ADA protocols it may take up to 21 days to process the application. Once application is processed you will be notified by mail of the decision.)**

# Section 2

Applicant Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**The following information 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 **Functional Disability Limitation** that **PREVENTS** use of the existing public transit service. If you have any questions regarding eligibility, please call the JETS Mobility Manager's office at (870) 935-5387 ext 1731. All final decisions regarding eligibility are made by the JETS Paratransit Service administrative staff and Transit Coordinator.

1. What is the medical diagnosis that causes the disability? (i.e. if seizures, list type and frequency)

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Date of Diagnosis? \_\_\_\_\_

2. How does the disability prevent the applicant from riding the fixed route city bus service? What are their functional limitations?

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List any medications that may impair or aid with mobility.

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Is there any pending Physical Therapy? Yes \_\_\_\_\_ No \_\_\_\_\_

If the applicant has a disability affecting mobility: Is the applicant able to walk or wheel self without assistance? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, how far? (3 blocks=1/4 mile)

Less than 1 block \_\_\_\_\_ 1 block \_\_\_\_\_ 3 blocks \_\_\_\_\_ 6 blocks \_\_\_\_\_ 9 blocks \_\_\_\_\_

Remarks \_\_\_\_\_  
\_\_\_\_\_

Using a handrail, is applicant able to climb three 10 inch steps without assistance? Yes \_\_\_\_\_ No \_\_\_\_\_

Remarks \_\_\_\_\_  
\_\_\_\_\_

If vision impaired, what is the Best corrected Acuity (Snellen)?

Right Eye \_\_\_\_\_ Left Eye \_\_\_\_\_

Field Restriction Right Eye \_\_\_\_\_ Left Eye \_\_\_\_\_

3. Does the applicant use any assistive devices? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes what devices?

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

4. Could the applicant use the Fixed Route Service?

Never \_\_\_\_\_ Sometimes \_\_\_\_\_ Always \_\_\_\_\_

Remarks \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Could the applicant benefit from Travel Training? Yes \_\_\_\_\_ No \_\_\_\_\_

5. Is applicants disability: Permanent \_\_\_\_\_ Temporary \_\_\_\_\_

Conditional \_\_\_\_\_

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

If conditional, what are conditions under which applicant cannot use Fixed Routes?

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

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 \_\_\_\_\_

**VERIFYING AGENCY OR PHYSICIAN INFORMATION**

**NAME** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

**PHONE** \_\_\_\_\_ **FAX** \_\_\_\_\_

**I (PRINT NAME)** \_\_\_\_\_ **certify that the above information is true and correct.**

**Signature of verifying Agent or Physician**

\_\_\_\_\_

**Date**

\_\_\_\_\_