JEFFERSON TRANSIT
Certification of ADA Paratransit Eligibility
Mobility Impaired Transportation System (MITS)

Instructions: PLEASE READ CAREFULLY and remove this sheet before returning application.

If you need assistance in completing the application or need the application provided in an alternate format, please call the MITS office (**504-889-7155**), and we will be happy to help you. The application must be complete before MITS can proceed with the review process. If the release forms are *not* signed, the application will be returned to the applicant.

Mail the completed application to:

Jefferson Transit MITS Office
118 David Dr., Metairie, LA 70003
Office: (504) 889-7155
Fax: (504) 324-0834

As soon as the completed application is received, the MITS Manager will mail a Healthcare Professional Certification form to the person named on the applicant's authorization form. Only after the Healthcare Professional Certification form is returned will the MITS Manager make an eligibility determination.

If you are qualified to use MITS, you will receive a MITS ID card and a MITS Rider's Guide that explains the policies and procedures. The MITS ID card has an expiration date on it, and you are responsible for recertifying every three years.

If you do not qualify and feel this was done in error, you may file a formal appeal. We will give you instructions on appealing at the time of your determination.

MITS serves urbanized Jefferson Parish and a limited area of Orleans Parish.

The MITS fare is currently $3.00 each way. There is no charge for a personal care attendant (PCA), but other accompanying guests are charged the same fare of $3.00.

Certification of ADA Paratransit Eligibility

Please type or print. Applications that are not fully completed or clearly written will be returned.

Name: _____
First Middle Last

Social Security Number: ____-___-_____ Date of Birth: _____

Home Address: _____ Zip Code: _____

Mailing Address (*if different than home address*):
_____ Zip Code: _____

Applicant's Phone:
Home _____ Work _____ Cell _____

Person to contact in case of an emergency

Emergency Contact Name: _____
Relationship: _____

Emergency Contact's Phone:
Home _____ Work _____ Cell _____

Primary physician or healthcare professional

Healthcare Professional Name: _____
Healthcare Professional's Phone: _____
Healthcare Professional's Address: _____
_____

Have you ever been certified to use MITS? Yes _____ No _____

If no, have you ever applied for MITS? Yes _____ No _____

If yes, give approximate date: _____

Are you able to ride on the Jefferson Transit fixed-route bus system?
Yes _____ No _____ Sometimes _____ I do not know _____

If no, please explain: _____

Using a mobility aid or on your own, how many blocks can you go on level ground?
___ Less than 2 blocks ___ 2 to 4 blocks ___ More than 4 blocks

How many blocks do you need to go to get to a JeT bus stop from your home?
___ Less than 2 blocks ___ 2 to 4 blocks ___ More than 4 blocks

Do you use any of the following mobility aids or equipment? Check all that apply.

[__] Cane [__] Power Wheel Chair [__] Communication Board

[__] White Cane [__] Large Power Wheel Chair [__] Service Animal

[__] Walker [__] Power Scooter (3-Wheeler) [__] Leg Braces

[__] Crutches [__] Manual Wheel Chair [__] Other (specify)_____

If you use a wheelchair or scooter, does your residence have a wheelchair ramp?
Yes ___ No ___

If you use a wheelchair or scooter, can you transfer from your wheelchair to a seat in a vehicle? Yes___ No___

Does a personal assistant (PA) accompany you when you travel outside your home (for example, to push your wheelchair, carry oxygen, etc.)?
Yes _____ No_____ Sometimes _____

I certify that the information I have given in this application is true and correct. I understand that falsification of information may result in denial of service. I understand all information will be kept confidential and only the information required to provide the services I request will be disclosed to those who perform the services.

Applicant's Signature _____

Date: _____

transdev
MOBILITY INSPIRED BY YOU

JEFFERSON PARISH TRANSIT
MITS (Mobility Impaired Transportation Service)

ONLY - DOCTOR, SOCIAL / CASE WORKER, THERAPIST OR HOMECARE NURSE CAN COMPLETE

Dear Applicant:

Please have your **PHYSICIAN** complete the Healthcare Professional Authorization Form and **MAIL** or **FAX** the completed form to:

MITS Program
Transdev / Jefferson Transit
118 David Dr.
Metairie, LA 70003
504-889-7155 office
504-758-9135 cell
504.324.0834 fax

We need the completed Healthcare Professional Authorization Form to complete the application process.

If you have any questions, please contact our office at **504-889-7155** and someone will help you.

Sincerely,

Contessa Gullage
MITS Paratransit Operation Manager

Jefferson Transit Fixed Route/MITS Program
Healthcare Professional Authorization Form

All Jefferson Transit fixed route and MITS buses are ADA accessible. The fixed route buses are equipped with a wheelchair lift, a lower step function and announce major bus stops and transfer points.

DOB:

Name of Applicant, _____ has authorized you to release to Jefferson Transit necessary information about his/her functional limitations and/or health-related condition as it affects the applicant's ability to use public transit. Information from the healthcare provider will be used along with the individual's application to determine the type of public transportation for which the applicant is eligible. The Healthcare Authorization Form is an important part of the application process.

1. Describe the applicant's disability that limits his/her mobility.

2. Does this disability prevent the applicant from using the regular bus service (fixed route bus service)? _____ Yes _____ No

If yes, describe in detail.

3. Is the condition permanent or temporary? _____
   If temporary, what is your projected date of recovery? _____

4. Since the transit system only offers "origin to destination" service, is your patient (while waiting for the bus or after being dropped off):

	Yes	No
a. capable of navigating distances alone?	_____	_____
b. able to ambulate without assistance?	_____	_____
c. able to independently respond to verbal or written instructions?	_____	_____
d. able to care for themselves while on the bus?	_____	_____
e. if using a mobility aid, is your patient mobile without needing help?	_____	_____

5. Does your patient use any of the following aids to facilitate their mobility?

	Wheelchair		Electric scooter
	Cane		Braces
	Walker		Crutches
	Service assistance animal		Prosthesis
	Other		

Based upon my professional knowledge of the applicant, I certify the preceding information is true and correct.

Name of Health Care Provider (Please print) _____
License, Certificate, or Registration Number _____
Type of Practitioner _____
Signature _____ Date _____