



Application for Handitran Special Transportation Service

Complete the form, including the signature portion of the Handitran Application. **Senior citizens 65 years and older must provide proof of age with the application. Persons under 65 years old must have their physician certify the Disability Certification stating that the applicant is transportation disabled.** A \$10 application fee must be received to complete the application process and does not guarantee the availability of rides.

Applicant's Name _____ Date of Birth _____
Email _____ Age _____ Gender _____
Address _____ Apt # _____
City _____ State _____ Zip _____
Name of Apartment Complex or Nursing Home: _____
Home Phone _____ Cell Phone _____

Person to Contact In Case of Emergency _____ Home Phone _____
Address _____ Other Phone _____
City _____ State _____ Zip _____
Relation _____

Personal Physician _____ Phone _____
Address _____ Suite # _____
City _____ State _____ Zip _____

Does the applicant require an attendant or supervision during transport?

- Yes Explain: _____
 No

Assistive Devices Used (Check All That Apply):

- | | | |
|-----------------------------------|---|--|
| <input type="checkbox"/> Cane | <input type="checkbox"/> Standard Manual Wheelchair | <input type="checkbox"/> Electric Conventional |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Portable Oxygen | <input type="checkbox"/> Service Animal: _____ |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Powered Scooter | <input type="checkbox"/> Other: _____ |

Brand and/or model number (if available) of the mobility device? _____

If using a wheelchair, does your residence have a wheelchair ramp for multiple steps? Yes No N/A

If using a service animal, what service does the animal provide? _____

(Driver cannot take a wheelchair up or down a step higher than 6" or more than one step; ramps must be secure)

Do you require assistance from the driver? Yes No _____

Do you have any condition of which we should be aware? Yes No _____

Have you ever filled out a Handitran service application before? Yes No

RELEASE AND INDEMNIFICATION

I covenant and agree that, for and in consideration of the City of Arlington allowing me to use the Handitran Special Transportation System, I do hereby agree to waive all claims, release, indemnify, defend and hold harmless the City of Arlington, its employees, agents, sponsors and volunteers assisting in the Handitran program, from all damages, claims, or liability of any kind, whatsoever, which may arise because of injury to or death of any person, or for loss of, damage to, or loss of use of any property occasioned by any error, omission, violation of Handitran's rules or regulations, or negligent act by me. Such indemnity applies whether the damages, claims, or liability arises in whole or in part from the error, omission, violation of Handitran's rules or regulations, or negligence of the City of Arlington or me. My expressed intention is that the indemnity provided in this paragraph is indemnity by me to indemnify and protect the City of Arlington from the consequences of The City of Arlington's negligence, whether that negligence is the sole or concurring cause of the injury, death, or damage.

BY SIGNING BELOW, I ACKNOWLEDGE:

RECEIPT OF POLICY INFORMATION: I have received the preceding information concerning Handitran policies and procedures and agree to abide by these policies.

VERIFICATION AND RELEASE OF INFORMATION: I verify that the information on this service application is true and correct to the best of my knowledge. I also authorize Handitran personnel to obtain verification of any information given in this application, including, but not limited to pertinent medical information necessary for clarification of ridership eligibility.

RELEASE AND INDEMNIFICATION: I have read the above release and indemnification, understand its terms and conditions, and execute it voluntarily and with full knowledge of its significance.

Dated, this, the _____ day of _____, 20 _____.

X

Applicant's Signature (Or Legal Guardian w/Power of Attorney)
(Please provide a copy of Power of Attorney)

DISABILITY CERTIFICATION

A physician must complete this page for applicants with disabilities who are under 65 years of age. Failure of a physician to complete this portion of the form may delay the certification or non-certification of an applicant. This section is not required for applicants 65 years of age or older if proof of age is submitted. However, completion is recommended, in addition to the evidence of age, to provide disability information.

ATTENTION PHYSICIAN:

An individual wishing to be certified with Handitran must be a senior citizen (65 years of age or older) or a restricted transportation individual with a physical/mental disability. The program is a subsidized shared-ride service that provides transportation to persons with a physical or mental disability that prevents motor vehicle safety.

- This applicant is not transportation restricted as described above.
- This applicant is transportation restricted as described above, and outlined as follows:

1. What is the applicant's specific disability or medical diagnosis? If the applicant's disability is obesity-related, please provide current weight:
2. Is the applicant's disability temporary or permanent?
 Temporary Permanent

If temporary, how long will the applicant need service?

- | | |
|--|---|
| <input type="checkbox"/> Less than one month | <input type="checkbox"/> Six months to one year |
| <input type="checkbox"/> One to three months | <input type="checkbox"/> One to two years |
| <input type="checkbox"/> Three to six months | <input type="checkbox"/> Over two years |

3. Does the patient have a history of/currently have violent tendencies, or will the patient present a behavioral problem during transport?
 Yes No

Explain _____

Physician's Signature _____ Date Completed _____

Physician's Name _____ Phone Number _____

Address _____ Fax Number _____

City _____ State _____ Zip _____