Oxford University Transit
409 McElroy Drive
Oxford, MS 38655
662-234-3540

Dear Applicant:

We appreciate your interest in OUT's Paratransit Service. Access is a curb-to-curb demand response service provided to disabled and elderly citizens. The enclosed application will determine your eligibility to use paratransit service. All applicants must live within the Oxford City Limits to be considered for Paratransit Services.

OUT paratransit is an ADA paratransit service, required by federal law, which OUT elects to provide for disabled residents. ADA service eligibility and certification is required in order to use the service.

The application must be filled out completely and legibly. The enclosed Physician's Verification of Disability Form must be completed by a doctor, licensed healthcare provider, or licensed rehab/social worker familiar with your disability.

You will receive a determination letter within 5 days of receipt of your application. If you require any assistance in completing this application you may call our office at 234-3540.

Again, we thank you for your interest in OUT's Paratransit Service.

Sincerely

Donna Zampella
General Manager

CERTIFICATION OF ELIGIBILITY

Return Completed application to :

Oxford University Transit
409 McElroy Drive
Oxford, MS 38655

OFFICE USE ONLY

Determination: ______

ADA Eligible Reduced Fare

Expiration Date:
3 Years ______ Other ______

Approved by: ______
Date: ______

PART 1 - General Information - Completed by Applicant - (Please print or type)

Name: ______

Street Address: ______ Gate Security # ______

Home Phone # ______ Cell # ______

Work Phone # ______ Date of Birth ______

Social Security # ______

In Case of Emergency Notify: ______

PART II - Disability and Mobility Equipment

How does your disability prevent you from using OUT's fixed route bus service? ______

______

______

Is your disability permanent Yes ______ No ______
If NO, expected duration of your disability ______
Have you ever had a seizure? Yes ______ No ______
If YES type? ______ How Often? ______
Are seizures controlled with medication? Yes ______ No ______
Do you have use of any of the following mobility aids? (Check all that apply)

☐	Manual Wheelchair	☐	Walker	☐	Service Animal
☐	Powered Wheelchair	☐	Cane	☐	Portable
☐	Powered Scooter	☐	Braces	☐	Crutches
☐	Prosthesis	☐	Other ______		

PART IV - Please initial all of the following statements indicating you have read and understand each statement:"

The following are my rights and responsibilites using the OUT Paratransit:

Access service is public transportation and I will be sharing rides with other passengers. ________

Access does not provide emergency service.. ________

I must show my Access ID and pay the fare each time I ride.. ________

Four "No Shows" in 30 days could result in suspension of service....................................... ________

Access operators may arrive 15 minutes before or 15 minutes after the scheduled pick up time... ________

Access operators will only wait 5 minutes from the time they arrive.................................. ________

Wheelchair lifts can accommodate up to 600 lbs, and 32 inches in width. I understand the combined weight of me, my wheelchair, and accessories must weigh less than 600 lbs. I also understand the width of my wheelchair cannot exceed 32 inches......... ________

OUT reserves the right to require a Personal Care Attendent (PCA) at any time of pick-up. If I am required to have a PCA at the time of pickup, and if I do not have one, I will be unable to ride.. ________

I certify the information provided is this application is accurate. I understand that false information may result in the denial or annulment of Paratransit Service. I further understand that all information will be kept confidential, and only the information required to provide the service I request will be disclosed to those who perform those services.

______________________________ ______________________________
Applicant Signature Date

*****If someone else is completing this application for the applicant please complete the following:**

Name: ______________________________ Relationship ______________________________

______________________________ ______________________________
Signature Date

______________________________ ______________________________
Home phone: Work Phon

____
Cell #

Oxford University Transit
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662-234-3540

Paratransit Service
Physician Verification and Disability Form

This form must be filled out in it's entirety. Incomplete forms will not be processed and will be returned to the patient. ***All applicants must be within the Oxford City Limits.***

Date: ____________________

Patient Name: ____

Date of Birth: ____

Social Sercurity Number: ________________________________

The person above is __________ **currently being treated or** ___________ **was formerly treated** by me. The person has informed me of his/her intent to apply for Oxford University Transit (OUT) Paratransit Service. The information provided in this form is intended to verify any medical/health conditions that **prevent** the applicant from using OUT's fixed route bus service.

Please Check One:

__________ Physician
__________ Licensed Healthcare Provider
__________ Licensed Rehab/Social Worker

Medical diagnosis and explanation of condition causing disability: ______________________________

____

____

____

Disability Status (Select One)

__________ Patient will be temporily disabled for ____________ months
__________ Patient is considered permanently disabled

Does the disability prevent the applicant from utilizing the OUT fixed route services (regular bus service)? If yes, please describe in detail. ____

____

____

Physician Verification of Disability Form cont.

Can the applicant walk or wheel 1/4 mile (3 blocks) without the assistence of another person?

_________ Yes _________ No

Can the applicant climb three (3) 10-in steps with assistance?

_________ Yes _________ No

Can the applicant wait outside without support for 15 minutes?

_________ Yes _________ No

Is the applicant of dialysis?

_________ Yes _________ No

Is the applicant able to recognize a destination or landmark?

Does the applicant have a hearing impairment?

Is the applicant able to give addresses and phone numbers upon request?

Is the applicant able to deal with unexpected situations or unexpected changes in routine?

Is the applicant able to ask for, understand, and follow directions?

Is th applicant able to safely and effectively travel alone through crowded and/or complex facilities?

The vehicle wheelchair left will accommodate up to 600 ;bs and are 32 inces in width. The applicants weight is ________________ lbs.

Mobility devise make and model: ____

Physician Verification of Disability Form cont.

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

Name (Please Pring) Office Phone Number

Office Street Address City State Zip

State License Number (Must be current)

Signature Date