RUTHERFORD COUNTY TRANSIT
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TTY FOR HEARING OR SPEECH IMPAIRMENTS DIAL 1-800-735-2962

Rutherford County TRANSIT DrivingPossibilities.com

Application for Elderly and Disabled Transportation Assistance Program

WHO IS ELIGIBLE?
Residents of Rutherford County age 60 and older and residents no matter what age who have a certifiable mental or physical disability, which substantially limits one or more major life activity. Residents who are determined to be eligible for the program may receive up to four (4) trips per month on a first come first served basis. More trips per month may be arranged upon referral by a medical professional.

WHAT TO DO?
Please fill out application ***completely***.
If you are under age 60, please have your physician or a medical professional certify your disability.

Last Name:_____ First Name:_____ M.I._____

Address:_____ City:_____ State: _____ Zip:_____

Mailing Address (if different from above):_____

Telephone: _____ - _____ - _____

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

1. Do you live alone? (Please check) _____ Yes _____ No
2. Do you have a driver's license? (Please check) _____ Yes _____ No
3. Do you own an automobile? (Please check) _____ Yes _____ No
4. Do you own your own home? (Please check) _____ Yes _____ No
5. Why do you need transportation? (Explain) _____

   _____
6. Do you receive Medicaid? (Blue Card) _____ Yes _____ No
7. Are you served by any of the following agencies? (Check all that apply):

Dept of Social Services:_____	Rutherford Life Services:_____	Mental Health: _____
Magnolia House: _____	Health Department: _____	Substance Abuse:_____
Dialysis: _____	One Source Rehab: _____	Rutherford Rehab:_____
Vocational Rehab: _____	Section 8 Housing: _____	Work First:_____
Cancer Center: _____	Cardiopulmonary Rehab:_____	Hospice:_____

8. List any other agencies from which you receive service: _____

   _____

9. If you are disabled, what is the nature of your disability? (Check all that apply)
_____Mental _____ Physical _____ Vision _____Hearing _____Other

Please Explain:_____

_____

10. Is your disability permanent? _____ Yes _____ No If No, how long do you expect to be disabled?_____

11. Are you in a wheelchair? (Please check) _____ Yes _____ No If Yes, is your residence wheelchair accessible by ramp or other means? Please Explain: _____

_____

12. Do you use any other assisted device? (Please check) _____Walker ____Cane _____Oxygen _____Other

If Other, please specify:_____

13. List the names and locations of each medical facility you visit on a regular basis:_____

_____

_____

14. Please give detailed directions to your home:_____

_____

_____

Your Signature: **X**_____ Date:_____

CERTIFICATION BY A MEDICAL PROFESSIONAL AS TO DISABILITY IS REQUIRED OF ALL PERSONS UNDER AGE 60 MAKING APPLICATION FOR SERVICE.

_____ (PLEASE PRINT) DO HEREBY CERTIFY THAT THE APPLICANT HAS A PHYSICAL OR MENTAL IMPAIRMENT THAT SUBSTANTIALLY LIMITS ONE OR MORE MAJOR LIFE ACTIVITY OR IS AN INDIVIDUAL WHO HAS A RECORD OF SUCH IMPAIRMENT, OR IS AN INDIVIDUAL WHO IS REGARDED AS HAVING SUCH IMPAIRMENT.

SIGNED X_____ DATE_____

Physician or Medical Professional

This application shall be valid for a period of (1) year from the date of application approval. EDTAP funds will be used to provide in county transportation except in cases in which a medical professional makes a referral to an out of county facility and no other means of transportation is available. Provisions of services under this program are subject to change based on availability of funding, equipment and personnel.