APPLICATION FOR MITS

Please return to:
FWTA (MITS) - 801 Cherry St., Suite 850 - Fort Worth,Texas 76102
(817) 215-8600 VOICE
(817) 215-8934 FAX

For Office Use Only
Date Received _____
I.D.# _____
Status Code _____
PCA _____
Mapsco Grid _____

SECTION 1

To be completed by applicant _ Please type or print

Have you ever been certified to use MITS? YES ☐ NO ☐ Date of Birth_____
If no, have you ever applied for MITS? YES ☐ give date_____

1. Name: Mr ☐ Ms ☐ _____
First Initial Last

2. **Home Phone** _____ WorkPhone_____

3. Home Address_____
Street or Box # City State Zip

Apartment Name & Number_____

Mailing address_____
(If different) Street or Box # City State Zip

4. Language Preference: English ☐ Spanish ☐ Braille ☐ Large Print ☐
AUDIO ☐ English/Spanish (circle one)

5. Emergency Contact _____ _____ _____
Name Relationship Daytime Phone

Address_____City_____State_____Zip_____

---

6. Assistive device used? Check all that apply:

Manual wheelchair ☐ **Electric wheelchair** ☐ **Powered scooter** ☐ **Portable Oxygen** ☐

Cane ☐ **Crutches** ☐ **Walker** ☐ **Prosthesis** ☐ **Mobility/White Cane** ☐

Service Animal ☐ **What service does animal provide?**_____

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

If **No** ramp, how many steps? _____ (Driver will not take a wheelchair up or down a step higher than 6" or more than one step.)

If more than one step, how do you transport your wheelchair to street level?_____

_____

8. If necessary, can you transfer yourself from a wheelchair to a passenger car? Yes ☐ No ☐

9. Have you ever used the city bus service? Yes ☐ No ☐ Have you ever had training to use the city bus service? Yes ☐ No ☐

Most frequent destinations- list addresses _____

_____

_____

Applicant Signature _____

Date _____

(Note: Once we have received a completed application with all required information, it may take up to 21 days to process it.)

SECTION 2: Applicant Name _____[for fax transmissions]

Date of Birth _____/_____/_____
(required) Mo / Day / Yr

For Office Use Only
NBR_____

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 disability that **PREVENTS** use of the existing public transit. Also keep in mind that we have a high volume of individuals who are interested in service, but the purpose of paratransit is **for those qualified persons whose only option for transportation is paratransit.** If you have questions regarding eligibility, please call the MITS office at 817-215-8600. All final decisions regarding eligibility are made by the MITS administrative staff.

10.What is the medical diagnosis that causes the disability?
(i.e., if mental retardation - list I.Q., seizures -list type, # per month)

_____

_____

Date of diagnosis _____

11. How does the disability prevent the applicant from riding regular city bus service? What are their functional limitations?

_____

_____

List any medications that may impair or aid with mobility._____

_____

Is there any therapy pending?_____ Expected results_____
If the person has a disability affecting mobility: Is the person: [check appropriate box(s)]

Able to **walk or wheel self** without assistance? Yes ☐ No ☐ (3 blocks = 1/4 mile)

less than1Block ☐ 1 Block ☐ 3 Blocks ☐ 6 Blocks ☐ 9 Blocks ☐

Remarks _____

Using a handrail, is applicant able to climb three 12 inch steps without assistance? Yes ☐ No ☐

Remarks _____

Able to wait outside in all weather conditions without support for at least 20 minutes? Yes ☐ No ☐

Remarks _____

If vision impaired, what is **Best Corrected Acuity** (Snellen)?

Right eye _____ Left eye _____ **Field Restriction:** Right_____ Left_____

12. Does this person use any assistive devices? If so, what?_____

Has this person ever had training to use the city bus service? Yes☐ No ☐ Do Not Know ☐
Could this person use regular city bus service? **never sometimes always** If wheelchair accessible? _____
Could this person benefit from Bus Route training? Yes ☐ No ☐

13. Is disability Permanent ☐ Temporary ☐
If temporary, how long will applicant need service? _____

14.All certified applicants are allowed to take a guest with them. Is the applicant required to have a personal care attendant to administer assistance with them? Yes ☐ No ☐
If needed, applicant must provide their own attendant.

Agency or Physician Name, Address, and Telephone

_____ ( ) _____/_____
Verifying Agency or Physician Name Area Code Phone Fax #

_____
Address City State Zip

15.I (PRINT NAME)_____ certify that the above information is true and correct.

Signature of Verifying Agency or Physician_____Date _____

Any additional information, please attach. Thank you for taking the time to complete this application.