PLUS NORMAN APPLICATION AND MEDICAL RELEASE

PLUS eligibility is based on the criteria and guidelines set forth in the Americans with Disabilities Act of 1990 (ADA) and Federal Transit Administration rules and decisions related to paratransit. To be determined eligible for PLUS, a person must have a disability or medical condition that prevents him/her from independently using the regular fixed-route bus system most of the time. This entire application must be completed in full by the applicant (or someone assisting the applicant). Please answer all questions, incomplete applications will be returned to the applicant without processing. **Return to: EMBARK, 2000 South May Avenue, Okla. City, Oklahoma 73108, fax 405-316-1668 or email to mobilitymanagement@okc.gov**

Part – A (Complete all Questions): PLEASE PRINT

Name (First, Middle, Last); _____

Date of Birth: _____ Sex: ☐ Female ☐ Male

Home Address: _____ Apt. #_____

City, State, and Zip Code: _____

Nearest Major Intersection: _____ Home Phone: _____

Facility/Apartment Name: _____ Cell Phone: _____

Email Address: _____ Work Phone: _____

Emergency Contact (Required); _____ Phone: _____

Relationship to Applicant: _____ Alternate Number: _____

1. What are your disabilities (check all that apply and provide a detailed description)?

☐	Physical disability	☐	Visual impairment/blindness
☐	Hearing impairment	☐	Developmental disability
☐	Mental Illness	☐	Other

Please describe the checked items above in greater detail: _____

_____

_____

Are any of the listed disabilities permanent? ☐ Yes ☐ No If yes, list which conditions?

_____

If no, what is the expected duration of the disability? _____ # of weeks _____ # of months

2. Do you require a Personal Care Attendant when traveling outside the home? (Check One)

☐ Yes, for all trips ☐ Sometimes, for certain types of trips ☐ No

3. Please check all of the assistive devices below that you may use when traveling:

☐ Manual Wheelchair ☐ Power Wheelchair ☐ Electric Scooter
☐ Service Animal ☐ Support/White Cane ☐ Walker
☐ Communication Device ☐ Portable Oxygen ☐ Crutches/Brace
☐ Other (Please describe) _____

4. If you use a wheelchair or scooter, is it more than 30 inches wide, more than 48 inches long, or is the occupied weight of your device more than 800 pounds? ☐ Yes ☐ No ☐ N/A

5. Do you have a functional and secure wheelchair ramp at your residence? ☐ Yes ☐ No

The questions below will help us evaluate your application and understand your functional abilities. Think about each question and determine whether you can perform the listed tasks consistently with a reasonable level of effort and risk.

All *Sometimes* answers must have an explanation.

6. Do you have the ability to see, read, understand and use the bus schedules needed to complete a trip (This question does not refer to being unaccustomed to the English language)?

☐ Yes ☐ Sometimes ☐ No EXPLAIN: _____

_____

7. Are you able to walk or use a mobility device to access bus stops if there are curbs, grassy areas, or uneven ground?

☐ Yes ☐ Sometimes ☐ No EXPLAIN: _____

_____

8. Are you able to wait 15 to 30 minutes at a bus stop or the Transit Center?

☐ Yes ☐ Sometimes ☐ No EXPLAIN: _____

_____

9. Are you able to safely cross streets and intersections with or without traffic lights?

☐ Yes ☐ Sometimes ☐ No EXPLAIN: _____

_____

0. Can you communicate with the bus driver to get information needed to complete your trip?

☐ Yes ☐ Sometimes ☐ No EXPLAIN: _____

_____

1. Can you board and exit the bus using the wheelchair ramp?

☐ Yes ☐ Sometimes ☐ No EXPLAIN: _____

_____

12. Are you able to determine when the bus has reached your designated stop?

☐ Yes ☐ Sometimes ☐ No EXPLAIN: _____

_____

13. Do you carry a cellular phone or are you otherwise able to communicate to reach help in case of an emergency at the bus stop or while traveling to/from the bus stop?

☐ Yes ☐ Sometimes ☐ No EXPLAIN: _____

_____

14. Are you able to maintain balance and tolerate movement of the bus when seated?

☐ Yes ☐ Sometimes ☐ No EXPLAIN: _____

_____

Agreement and Authorization

I certify that the information provided in this application is accurate and correct. I authorize the release of diagnostic and functional ability information to EMBARK for the sole purpose of making a determination regarding my eligibility for EMBARK Plus Paratransit service. I understand that all personal and medical information will be kept confidential and that intentionally supplying false or misleading information may be grounds for denial of EMBARK services and benefits.

If approved for EMBARK Plus Paratransit service, I agree to follow the rules and service guidelines established by EMBARK and to inform EMBARK promptly of any changes to my residence, phone number, emergency contact information, and any significant changes in my condition that would affect my level of mobility or eligibility for EMBARK Plus Paratransit services. I understand that failure to follow EMBARK Plus User's Guide procedures, failure to abide by EMBARK's *Rules of Conduct and Transit Exclusion Policy and Procedures*, or if my condition at any time poses a direct threat to the health or safety of others may result in suspension and/or termination of services or benefits.

Applicant Signature: _____ Date:

If this application was completed by someone other than the person requesting certification for EMBARK Plus eligibility, the following must be completed:

Name: _____ Relationship to Applicant: _____

Mailing Address: _____

Daytime Phone Number: _____ Email: _____

Signature: _____ Date: _____

How will I know if my application has been approved? After receiving your application, we will fax a medical information release to your physician for information about your disability. After we receive your medical information, we will evaluate your application and inform you of your eligibility determination within 21 days. If you are eligible, you will receive an EMBARK Plus User's Guide with information on scheduling a ride. If you are found ineligible, you will receive information on your right to appeal the decision and instructions for filing an eligibility appeal. If you have not received your eligibility determination letter within 21 days, call us at 405-235-RIDE (7433).

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

As part of your paratransit eligibility determination, EMBARK will contact your current doctor for information on your medical condition and your functional abilities. Please list the doctor or licensed healthcare professional most familiar with your condition. All information received will be kept confidential and only utilized by EMBARK Plus staff to determine your eligibility for ADA Paratransit Services. Refusal to provide this release will prevent EMBARK from completing your eligibility determination and will result in a denial of your application.

EMBARK DOES NOT PAY FOR MEDICAL INFORMATION

OR FORM COMPLETION FEES

Please print and complete all blanks

Patient First Name: _____ **Date of Birth:** _____

Patient Last Name: _____

Patient Street Address: _____

City: _____ **State:** _____ **Zip:**

Patient Home Phone Number: _____ **Cell:** _____

Physician Name: _____

Name of Office/Practice Group: _____

Street Address: _____

City: _____ **State:** _____ **Zip:**

Phone Number: _____ **Fax Number:** _____

Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by the Privacy Regulation.

CERTIFICATION AND AUTHORIZATION

I understand that falsification of information may result in denial of EMBARK Plus service. I authorize the licensed health professional listed above to release to EMBARK Plus information about my disability and its effect on my functional ability to travel on the fixed route bus. Unless earlier revoked in writing, this form permits the professional listed to release information to EMBARK up to one year from the date below.

_____ _____
Applicant Signature Date

_____
Print Name

_____ _____
Signature of person assisting applicant (if any) Relationship to Applicant