APPLICATION FOR DETERMINATION OF ELIGIBILITY

(For Applicants in the Jefferson/Shelby Urbanized Areas)

All individuals who are disabled or 60 years of age and over are able to qualify for subsidized transportation in the urbanized areas of Jefferson and Shelby counties. Qualification must be determined through an application process. All information is confidential.

Please fill out all pertinent parts of this application and return with supporting documentation to ClasTran.

Email: certification@clastran.com

Fax: 205-325-8788

U.S. Mail: ClasTran
PO Box 10386
Birmingham, AL 35202-0386

For questions or information:
205-325-8787
877-826-7876
certification@clastran.com
Between 8:00 a.m. and 5:00 p.m.

A. PERSONAL INFORMATION

Last Name: **First Name:** **Middle Initial:**

Home Phone: **Mobile Phone:**

Date of Birth: **Email Address:**

Street Address:

Number and Street:

City, State, Zip:

Mailing Address, if different:

Number and Street:

City, State, Zip:

In Case of Emergency Notify:

Name: **Phone:**

Address: **City:** **State:** **Zip:**

For office Use Only:

☐ Approved
☐ Denied
☐ Incomplete _____

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B. AGE QUALIFICATION

If you qualify because you are 60 years of age or over, please submit a copy of one of the following items as verification.

- State Driver's License
- State Identification Card
- Birth Certificate
- Medicare Card
- Passport
- U.S. Military ID
- Certificate of U.S. Citizenship
- Permanent Resident Card
- Alien Registration Receipt Card

IF YOU ARE AGE 60 OR OVER, DO NOT FILL OUT THE NEXT SECTION OR PAGE FOUR. PLEASE PROCEED TO SECTION D.

C. DISABILITY QUALIFICATION

If you qualify because of a disability, please provide detailed information of your disability or condition.

Is your disability temporary? Yes ☐ No ☐

If yes, please explain and provide an estimate of duration.

Proof of disability is required in order to complete your application. You must have the Professional Verification form completed by a professional who can verify your condition, including but not limited to: physician, registered nurse, social worker, psychologist, nurse practitioner, chiropractor, occupational therapist, physician's assistant, or mental health professional.

D. MOBILITY INFORMATION

Please check all mobility aids that you use.

- ☐ Cane
- ☐ White Cane
- ☐ Crutches
- ☐ Walker
- ☐ Service Animal*
- ☐ Electric Wheelchair**
- ☐ Manual Wheelchair
- ☐ Extra Wide Wheelchair**
- ☐ Powered Scooter**
- ☐ Other (please describe)

*If you use a service animal, please identify the type of animal and how it assists you.

****NOTE:** In order for ClasTran to provide service, wheelchairs cannot exceed 30" wide, 48" long, and 600 pounds when occupied, in accordance with the Americans with Disabilities Act of 1990, subpart A. ClasTran cannot transport mobility devices that exceed these standards.

E. PERSONAL CARE ATTENDANT

Do you ever have need for someone to assist you when you travel? Yes ☐ No ☐

F. CERTIFICATION

I certify that the information I have provided in this application is true and correct. I understand that falsification of information may result in denial of service. I further understand that all information required herein will be considered confidential and will be used only by ClasTran to determine eligibility for transportation services.

I understand that all services are curb-to-curb and that the operators will assist me on and off the vehicle, but not to the door or into a residence or building.

I agree to comply with all guidance and instruction for riders as contained in both the Rider's Guide and Rider's Handbook.

Name: (please print)

Signature: **Date:**

PROFESSIONAL VERIFICATION

_____ has submitted an application for transportation services and has indicated that you can provide verification of his/her disability.

This form must be completed by a currently-licensed professional who is able to certify the individual's disability, including but not limited to: physician, registered nurse, social worker, psychologist, nurse practitioner, chiropractor, occupational therapist, physician's assistant, or mental health professional. Please take a moment to fill out this questionnaire and return to the client or ClasTran at:

Email: certification@clastran.com

Fax: 205-325-8788

U.S. Mail: ClasTran
PO Box 10386
Birmingham, AL 35202-0386

1. Please describe the above person's disability.

2. Is this disability temporary?

☐ Yes ☐ No

3. If yes, please indicate the estimated length of disability.

4. In what capacity do you know the applicant?

5. Professional Verification

Signature: _____ Date: _____

Print Name: _____ Title: _____

License Title: _____ Number: _____ Expiration Date: _____

Agency Name: _____ Phone: _____

Address: _____

Please complete all sections of verification. Incomplete sections will result in delayed processing.