

# PARIS METRO PARATRANSIT APPLICATION

Complete this form and return it to: Ark-Tex Council of Governments  
240 10<sup>th</sup> SE Bldg. 5, Paris, TX 75461  
903-739-2444  
EMAIL to: slong@atcog.org

**THE BOTTOM PORTION OF THIS FORM MUST BE FILLED OUT BY A MEDICAL PROFESSIONAL**

NAME (Last, First, Middle Initial)		Phone No. (Include Area Code) Home: Cell:		Date of Birth	
Street Address, City, State, Zip Code					
Do you require a Personal Care Attendant? <input type="checkbox"/> YES <input type="checkbox"/> NO		Do you use a wheelchair? <input type="checkbox"/> Manual <input type="checkbox"/> Electric			Scooter <input type="checkbox"/> YES <input type="checkbox"/> NO
If visually impaired, do you use a guide dog? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you use a cane? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you use a walker? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Person to notify in case of emergency					
Name _____		Phone No. _____			
Applicant Signature: _____		Date: _____			
If application is being completed by someone other than the applicant, please complete the line below.					
Name: _____		Relationship: _____			
<b>***THE SECTION BELOW MUST BE COMPLETED BY MEDICAL PROFESSIONAL***</b>					
Disability/Medical Diagnosis (Define WHY applicant cannot ride the fixed route bus system in detail)					
Does the client require a Personal Care Attendant? <input type="checkbox"/> YES <input type="checkbox"/> NO		Combined Weight of Client & Wheelchair: _____ pounds		This is a(n): <input type="checkbox"/> Standard <input type="checkbox"/> Oversized Wheelchair	
Medical Professional Phone	Facility Name	Verifying Professional Name (Print)	Verifying Professional Signature		
<b>FOR PARIS METRO OFFICE USE ONLY</b>					
Authorized by & Date		<input type="checkbox"/> APPROVED <input type="checkbox"/> New <input type="checkbox"/> Recertification <input type="checkbox"/> DENIED (If checked, complete next line)			
Please state reason for denial					

**ANY APPLICANT WHO IS DENIED ELIGIBILITY ARE GIVEN UP TO 60 DAYS TO APPEAL THE DECISION IN WRITING**