





Span, Inc.  
1800 Malone St  
Denton, TX 76201  
940.382.1900

\_\_\_\_\_  
City State ZIP Code

\_\_\_\_\_  
Home Phone Cell Phone

Is Emergency Contact the Primary Caregiver?  YES  NO

Do you have any information that would be helpful to know in the event of an emergency (i.e. medical conditions, allergies, etc.)? \_\_\_\_\_

**SERVICE INFORMATION**

I would like to request the following services:

- General Transportation
- Veterans Transportation
- Disability Transportation\*\*

\*\* Rider requesting service may qualify for a reduced fare if he/she is over the age of 60 or has a verifiable disability. (Note: Residents in certain contract cities are not eligible and other restrictions may apply.) The Disability Certification Form can be found on the back of this application. The application must be filled out completely and legibly. The enclosed Physician's Certification of Disability Form must be completed by a doctor or human services professional familiar with your disability.

**ACKNOWLEDGEMENT**

- I understand my rights and responsibilities for Span Transit Service..... \_\_\_\_ (Initials)
1. Span service is public transportation and I will be sharing rides with other passengers..... \_\_\_\_
  2. Span does not provide emergency services..... \_\_\_\_
  3. I must pay the Fare each time I board the Span vehicle..... \_\_\_\_
  4. Three (3) "No Shows" in 30 days could result in a suspension of service..... \_\_\_\_
  5. Five (5) "Late Cancellations" in a 30 day period could result in a suspension of service..... \_\_\_\_
  6. Span Transit Operators may arrive 15 minutes before or after the scheduled pick up time..... \_\_\_\_
  7. Span Transit Operators will only wait 5 minutes from the time they arrive..... \_\_\_\_
  8. I understand that Span can only transport mobility devices that can fit onto the wheelchair lift..... \_\_\_\_
  9. If I am required to have a Personal Care Attendant at the time of pickup and do not have one, I will be unable to ride..... \_\_\_\_



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I have read and agree to adhere to the policies of Span. I certify that the information provided in this application is accurate. I understand that false information may result in the denial or annulment of Span Transit services. I further understand that all information will be kept confidential, and only the information required to provide the services I request will be disclosed to those involved in the performance of those services.\*\*

Rider's Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*If someone other than the rider is completing this form or has assisted the rider, that person must complete the following:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Questions?** Call the Span office at (940) 382-1900 or (940) 382-2224

Submit completed form to:

**Span, Inc.**  
**1800 Malone St.**  
**Denton, TX 76201**

**OFFICE USE ONLY**

<u>Documentation:</u>	<u>Determination:</u>	<u>Expiration Date:</u>
Application ___/___/___	<input type="checkbox"/> ADA Eligible	3 years      Other _____
Certification Form ___/___/___	<input type="checkbox"/> Temporarily Eligible	Approved By: _____
Supporting Docs ___/___/___	<input type="checkbox"/> Conditionally Eligible	Approval Date: ___/___/___
Response Sent ___/___/___	<input type="checkbox"/> Non-ADA Elderly Eligible	



### DISABILITY CERTIFICATION FORM

In order to receive a reduced Passenger Fare, rider must be over the age of 60 or have a verifiable disability. A physician or certified Human Services Professional must complete this form.

Rider Name (First, MI, Last) \_\_\_\_\_

#### MEDICAL INFORMATION

**Primary Care Physician Name and Title:**

**Physician Phone Number:**

**Fax Number:**

**Medical Condition/Health Status of Applicant:**

#### DISABILITY AND ACCOMODATION INFORMATION

Is the individual able to drive?  YES  NO

Is the disability permanent?  YES  NO If no, expected duration of disability? \_\_\_/\_\_\_/\_\_\_

Specify limitations the individual's mobility and any relevant information about individual's functional limitations:

Is the individual able to handle money?  YES  NO

Is the individual able to keep balance while seated on a moving bus?  YES  NO

Can the individual use railings or handles?  YES  NO

Is the individual able to understand and follow directions?  YES  NO

Specify the accommodations, including equipment aids, or services, required by the rider. Check all that apply.

<input type="checkbox"/> <b>Manual Wheelchair:</b> Make _____ Model _____ Year _____ Weight of wheelchair _____ lbs	<input type="checkbox"/> <b>Walker</b> <input type="checkbox"/> <b>Service Animal</b> <input type="checkbox"/> <b>Prosthesis</b> <input type="checkbox"/> <b>Crutches</b> <input type="checkbox"/> <b>Cane</b> <input type="checkbox"/> <b>Portable Oxygen</b> <input type="checkbox"/> <b>Braces</b>
<input type="checkbox"/> <b>Powered Wheelchair:</b> Make _____ Model _____ Year _____ Weight of wheelchair _____ lbs	



Transit within Reach

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Form with checkboxes for Powered Scooter, Personal Attendant, and Other. Includes fields for Make, Model, Year, and Weight of wheelchair. Also includes a question about transferring to a seat with YES/NO options.

PHYSICIAN OR HUMAN SERVICES PROFESSIONAL CERTIFICATION

(Examples of licensed or certified human services professionals include: Medical Doctor, Psychiatrist, Psychologist, Social Worker, Rehabilitation Professional, Physical/Occupational Therapist, Physician's Assistant, Nurse Practitioner, Registered Nurse)

I certify that I am the physician or certified human services professional listed in the application. I further certify that the information provided in this application, including information regarding the rider's age, description of disability, and functional limitations is accurate.

Physician or Certified Human Services Professional Signature \_\_\_\_\_

Provider Phone \_\_\_\_\_ Date \_\_\_\_\_