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

SPAN TRANSPORTATION RIDER APPLICATION

The information on this form is required by Span in order to complete your rider registration. All information will be kept confidential and guarded against unofficial use. Information gathered through this form may be shared to effectively plan, arrange and deliver services to meet individual rider needs. For any questions, please call Span at (940)382-1900.

RIDER INFORMATION

_____ _____
Date *Name (First, MI, Last)*

_____ _____ _____
Home Phone *Cell Phone* *Email Address*

_____
Street Address (including apartment number)

_____ _____ _____
City *State* *ZIP Code*

_____ _____
Date of Birth *Gender*

Is your primary language English? ☐ **YES** ☐ **NO**

If "NO", please list Primary Language: _____

Choose one Ethnic Identity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Choose one or more Racial Identities (regardless of ethnicity):

Do not wish to disclose ☐

☐ White ☐ Asian ☐ Black or African American

☐ Native Hawaiian or other Pacific Islander ☐ American Indian or Alaska Native

Annual Income Level (not used for eligibility purposes) ***Answering will help us help others:***

☐ Greater than $21,020 individual or $45,177 household ☐ Less than $21,020 individual or $45,177 household

Have you utilized Span Transit in the past? ☐ **YES** ☐ **NO** If yes, when? ____/____/_____

Do you use a cane? ☐ **YES** ☐ **NO** Do you use a walker? ☐ **YES** ☐ **NO**

EMERGENCY CONTACT INFORMATION

_____ _____
Relationship to Rider *Name (First, Last)*

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Street Address

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

Documentation:	**Determination:**	**Expiration Date:**
Application ____/____/___	☐ ADA Eligible	3 years Other_____
Certification Form___/____/____	☐ Temporarily Eligible	
Supporting Docs ___/___/____	☐ Conditionally Eligible	Approved By:_____
Response Sent ___/___/____	☐ Non-ADA Elderly Eligible	Approval Date: ___/___/___

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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.

☐ **Manual Wheelchair:** Make_____ Model_____ Year_____ Weight of wheelchair _____ lbs	☐ **Walker** ☐ **Service Animal** ☐ **Prosthesis** ☐ **Crutches** ☐ **Cane** ☐ **Portable Oxygen** ☐ **Braces**
☐ **Powered Wheelchair:** Make_____ Model_____ Year_____ Weight of wheelchair _____ lbs	

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☐ **Powered Scooter:** Make_____ Model_____ Year_____ Weight of wheelchair _____ lbs	☐ **Personal Attendant** ☐ **Other: _____** _____
Is individual able to transfer to a seat? ☐ **YES** ☐ **NO**	

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_____