

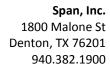


Rider

## 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 INFORMATIO	DN			
Date	 Name (First, MI, La	st)		
	, , , , , , , , , , , , , , , , , , , ,	<del>- ,</del>		
Home Phone	Cell Phone	•	Email Address	
Street Address (include	ding apartment number)			
City	State	-	ZIP Code	
Date of Birth		Gender		
Is your primary lang	uage English?	YES 🗌 NO		
If "NO", please list F	Primary Language:			
Choose one Ethnic	dentity: Hispan	ic/Latino	Not Hispanic/Latino	
Choose one or more	Racial Identities (reg	ardless of ethnicity):		. 🗖
☐ White	☐ Asian	☐ Black or African	Do not wish to dis	sciose
☐ Native Hawaii	an or other Pacific Islan	der	n Indian or Alaska Native	
Annual Income Leve	el (not used for eligibil	ity purposes) <i>Answeri</i>	ng will help us help othe	rs:
☐ Greater than \$21,0	020 individual or \$45,17	7 household Less th	an \$21,020 individual or \$	45,177 household
Have you utilized Spar	Transit in the past?	☐ YES ☐ NO	If yes, when?/_	
Do you use a cane?	☐ YES ☐ NO	Do you use a walker?	☐YES ☐ NO	
EMERGENCY CONT	ACT INFORMATION			
Relationship to	— Name (First, Last)			





Street Address			
City	State	ZIP Code	_
Home Phone	Cell Phone		
Is Emergency Contact the F	Primary Caregiver?   YES	□NO	
	that would be helpful to know in th	ne event of an emergency (i.e. medical con	ditions,
ERVICE INFORMATION			
☐ General Transportation ☐ Veterans Transportation ☐ Disability Transportation	1		
verifiable disability. (Note: R apply.) The Disability Certific must be filled out completely	esidents in certain contract cities cation Form can be found on the	ne/she is over the age of 60 or has a s are not eligible and other restrictions m back of this application. The application ician's Certification of Disability Form nal familiar with your disability.	
CKNOWLEDGEMENT			
I understand my rights and re	esponsibilities for Span Transit S	ervice	(Initial
		ides with other passengers	_
2. Span does not provide em	ergency services	······	
3. I must pay the Fare each	ime I board the Span vehicle	<u> </u>	
4. Three (3) "No Shows" in 3	0 days could result in a suspensi	on of service	
5. Five (5) "Late Cancellation	ns" in a 30 day period could resul	t in a suspension of service	
6. Span Transit Operators m	ay arrive 15 minutes before or af	ter the scheduled pick up time	
7. Span Transit Operators wi	Il only wait 5 minutes from the tir	ne they arrive	
•	Personal Care Attendant at the ti	that can fit onto the wheelchair lift me of pickup and do not	





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 ride the following:	r is completing this form or has	assisted the rider, that per	son must complete
Name	Relationship		
Phone			
Signature		Date	_
Questions? Call the Span office	e at (940) 382-1900 or (940) 38	32-2224	
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: / /	





## **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:					
Medical Condition/Health Status of Applicant:					
DISABILITY AND ACCOMODATION I	NFORMATION				
Is the individual able to drive? $\Box$ YES	□ NO				
Is the disability permanent? Tes Ino 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	e seated on a moving bus?				
Can the individual use railings or handles?	YES NO				
Is the individual able to understand and fol	low directions?				
Specify the accommodations, including eq	uipment aids, or services, required by the rider. Check all that apply.				
Manual Wheelchair:	☐ Walker				
Make Model	☐ Service Animal				
Year	☐ Prosthesis				
Weight of wheelchair lbs	☐ Crutches				
☐ Powered Wheelchair:	☐ Cane				
Make Model Year	☐ Portable Oxygen				
Veight of wheelchair lbs					



## Transit within Reach

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

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

☐ Powered Scooter:	☐ Personal Attendant
Make Model Year	☐ Other:
Weight of wheelchair lbs	
Is individual able to transfer to a seat?	
☐YES ☐ NO	
PHYSICIAN OR HUMAN SERVICES PROFES	SSIONAL CERTIFICATION
` · · · ·	es professionals include: <i>Medical Doctor, Psychiatrist,</i> lessional, Physical/Occupational Therapist, Physician's
	in services professional listed in the application. I further certify, including information regarding the rider's age, description of
Physician or Certified Human Services Profession	onal Signature

Date\_\_\_\_\_