



TRANSIT SYSTEM

M.A.P.

MOBILITY ASSISTANCE PROGRAM

Application

Applicant Name: _____

Date Received: _____

Approve by: _____

Date Approved: _____

Ride the Wave

The Wave Transit System
1224 West I-65 Service Road South • Mobile, AL 36609
Phone: (251) 344-5656 • Fax: (251) 344-9395
www.thewavetransit.com

CURRENT TRANSPORTATION

Do you use The Wave's bus system now?

- Yes If yes what Routes: _____
 No
 Sometimes

If no or sometimes, please explain: _____

Can you get to the bus stop by yourself?

- Yes
 No

If no please explain: _____

Can you board the bus by yourself?

- Yes
 No

If no please explain: _____

Have you received any training to use the fixed route bus service?

- Yes If yes by who: _____
 No

If you are found eligible for MAP Services, will you?

- Be able to meet the van at the curb
 Do you need assistance from your door
 Do you need assistance from the van to the door to your destination

Please check the reason you are applying for the Mobility Assistance Program (MAP)?

- A. Because of my disability, I can never use The Wave's fixed route buses.
Please explain why your disability prohibits you from using fixed route buses: _____

If you picked box A you do not need to answer question B.

- B. I can use The Wave's fixed route buses to go to some places, but in other places I cannot get to and from the bus stops. Please list other locations (complete address) and reason you can not use fixed route buses to get to those locations: _____

ASSISTIVE DEVICES USED

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Oxygen Tank | <input type="checkbox"/> Communication device |
| <input type="checkbox"/> Electric Wheelchair | <input type="checkbox"/> Prosthetics | <input type="checkbox"/> Service Animal |
| <input type="checkbox"/> Powered Scooter | <input type="checkbox"/> Crutches | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Walker (foldable) | <input type="checkbox"/> Leg Braces | |
| <input type="checkbox"/> Walker (non-foldable) | <input type="checkbox"/> Cane | |

The weight capacity for client and wheelchair/scooter is 600 pounds. Wheelchair/scooter cannot exceed 30 inches wide, 48 inches long.

Do you meet this requirement?

- Yes
 No

If No, The Wave Transit will be unable to transport you.

INFORMATION ABOUT DISABILITY

What type of disability prevents you from using The Wave's fixed route buses?

- | | |
|--|---|
| <input type="checkbox"/> Physical Disability | <input type="checkbox"/> Developmental Disability |
| <input type="checkbox"/> Visual Disability | <input type="checkbox"/> Cognitive Disability |
| <input type="checkbox"/> Mental Disability | |

For each disability checked please explain:

Is the disability you described above temporary or permanent?

- Temporary
 Permanent
 If Temporary, expected duration-until: _____
Date of Duration

Do you require the assistance of Personal Care Attendant (someone who must assist you with daily life functions)?

- Yes
 No

APPLICANT'S AGREEMENT

I understand the purpose of this application is to determine if there are times when I cannot use The Wave's fixed route service and must therefore use the Mobility Assistance Program (MAP).

I understand the information about my disability contained in this application will be confidential and shared only with professionals involved in evaluating my eligibility.

I certify that the information in this application is true and correct.

I authorize the licensed professional to provide verification to release information related to my disability to The Wave Transit System in order to assess my eligibility.

I agree that if I am certified for MAP, I will pay exact fare in the form of a **TICKET** for each trip. I agree to notify The Wave Transit System of any changes in my status, which may affect my eligibility to use the service. I also understand that failure to adhere to policies and procedures will be grounds for revoking or suspending my application and the right to participate in the program.

Signature

Date

The following information is to be completed if a person other than the applicant completed the application.

Name: _____ Day Time Phone: _____

Address: _____
Street Apt. No. City State Zip

Signature

Date

VERIFICATION OF ELIGIBILITY

This page and the following pages must be completed by qualified professional.

PLEASE PRINT

Person Completing Application: _____

Professional Title: _____ Agency/Affiliation: _____

Business Address: _____
Street Apt. No. City State Zip

Business Phone: _____ Fax: _____

State of Alabama License Number: _____

If you mark NO to any of the numbered items below, please explain.

1. What is the medical diagnosis that caused the disability (e.g. Mental Retardation, epilepsy)?

Is applicant's condition temporary?

Yes

No

If YES, expected duration-until: _____

Date of Duration

2. Does the applicant's disability require that he or she travel with an attendant?

Yes

No

3. Is there any other medical information The Wave should know in the event of an emergency (e.g. Hepatitis, Tuberculosis)?

DISABILITY AFFECTING MOBILITY

4. Is Applicant able to:

A. Travel a distance of 200 feet without assistance?

Yes

No

Explain: _____

B. Travel a distance of one block (1/4 mile) without assistance over different types of terrain?

Yes

No

Explain: _____

Able to climb three 12-inch steps without assistance?

Yes

No

Explain: _____

Able to wait outside without support for 15-30 minutes in all weather conditions?

Yes

No

Explain: _____

VISION IMPAIRED

5. Is Applicant able to:

Travel a distance of 200 feet without assistance?

Yes

No

Explain: _____

Travel a distance of one block (1/4 mile) without assistance over different types of terrain?

Yes

No

Explain: _____

Climb three 12-inch steps without assistance?

Yes

No

Explain: _____

Wait outside without support for 15-30 minutes in all weather conditions?

Yes

No

Explain: _____

COGNITIVE DISABILITY

6. Is Applicant able to:

Give name, address and telephone numbers upon request?

Yes

No

Explain: _____

Sometimes

Explain: _____

Recognize a destination or landmark?

Yes

No

Explain: _____

Sometimes

Explain: _____

Deal with unexpected situations or unexpected changes in routine?

Yes

No Explain: _____

Sometimes Explain: _____

Ask for, understand, and follow directions?

Yes

No Explain: _____

Sometimes Explain: _____

Please describe any other functional limitation(s) affecting mobility not described above. Please be specific

SPEECH IMPAIRED

7. Is Applicant able to:

Communicate verbally?

Yes

No Explain: _____

Sometimes Explain: _____

Communicate in writing?

Yes

No Explain: _____

Sometimes Explain: _____

Communicate over telephone?

Yes

No Explain: _____

Sometimes Explain: _____

SIGNATURE OF QUALIFIED PROFESSIONAL

I verify that the information provided above for verification is true and correct to the best of my knowledge.

Signature of Qualified Professional

Date