Trumbull County Transit (TCT)

Client Registration Form

Disabled Program Eligibility Form

Criteria for Disabled Certification Policy

Applications can be emailed cesalamo@co.trumbull.oh.us, mailed 106 High Street Warren, Ohio 44481, or faxed to Trumbull County Transit: (330) 675-7941 by the Physician that completes the section for the Licensed Medical Professional. PLEASE NOTE: REQUIRED DOCUMENTATION MUST ACCOMPANY THE APPLICATION. TCT will review the documentation, and sign and date the application form.

Trumbull County Residents with Disabilities: The documentation required for individuals with disabilities to be eligible includes a copy or facsimile of written documentation from a physician, or other licensed healthcare professional indicating that the person meets the criteria established by the Americans with Disabilities Act.

The certification is valid for a period of three (3) years and those passengers who wish to continue in the program must be re-certified at the time.

Trumbull County Transit Administrator
106 High Street
Phone: (330) 675-2873
Fax: (330) 675-7941

I have read the above Policy and agree that the information submitted is correct and accurate. I give permission to Trumbull County Transit to release my name to an appropriate agency so that I may qualify for this assistance.

Section 1

Last Name: _____ First name _____ MI_____

Street Address: _____ APT/Bldg.#_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone:_____

Mobile Phone: _____ E-Mail Address:_____

Date of Birth: _____ Sex M____ F____

Emergency Contact: Name: _____

Phone: _____

Relationship _____

Do you use any of the following equipment or assistive devices?

☐ **Manual Wheelchair** ☐ **Electric Scooter** ☐ **Walker** ☐ **Cane/Crutches** ☐ **Oxygen**
☐ **Service animals/ describe** _____

☐ **Electric Wheelchair** ☐ **Prosthesis** ☐ **111Respirator**
☐ **Other**_____

Do you require the assistance of a Personal Care Attendant (PCA)?

☐ Yes ☐ NO

(Signature)_____ **Date:** _____

Section 2

This Section for Licensed Medical Professional Only!

Clients Name _____

Nature of Disability:

☐ Physical

☐ Psychological

☐ Developmental

Brief Explanation: _____

_____

Is condition temporary? Yes or No If yes, for how long? _____

Does applicant need a PCA? Yes or No

Disability significantly affects applicant's ability to perform the following functions:

_____

_____

_____

Primary Physician Name (Print): _____

Office Phone Number: _____Physician Certification Number #_____

Physician Signature: _____ **Date: _____**

This Section for Trumbull County Transit Office Only!

Approved: ☐ Not Approved: ☐

Signature of Trumbull County Transit Administrator:

_____

Date: _____ **Expiration Date: _____**