



OFFICE USE ONLY

Date:	
Reviewer Name:	
Service Type:	
Account #:	
Route Match:	

**Collin Country Transit
APPLICATION**

I understand that the information I provide will be used to determine my initial and continuing eligibility for Collin County Transit services to be provided by DCTA on behalf of my city. For assistance with this form or to determine eligibility, please call 940.243.0077.

CONTACT INFORMATION

Name: First _____ Middle _____ Last _____

Home Phone _____ Cell Phone _____

Home Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Email _____

Date of Birth (Month/Day/Year) _____ Gender: Male Female

Emergency Contact

1. First _____ Last _____

Phone Number _____ Relationship _____

2. First _____ Last _____

Phone Number _____ Relationship _____

Do you use a mobility aid? (check all that apply)

Manual Wheelchair Powered Wheelchair I do not use a wheeled device Other _____

If you use a wheeled device, please provide the information below:

Height _____ Width _____ Depth _____ Weight (device plus occupant) _____

Do you require the assistance of a Personal Care Attendant (PCA) to travel? Yes No

Required Eligibility Documentation

Eligibility Criteria	Certifying Document Provided (Specify)
65+ years of age OR proof of disability <i>Examples: Doctor's note, SSDI letter, Medicare ID card</i>	
Proof of Residency <i>Examples: Recent utility bill, rental agreement or letter of residency, along with a picture ID</i>	

The remaining questions are for informational purposes only and do not affect eligibility for services.

Ethnicity:

- Black or African American Asian White Hispanic or Latino American Indian or Alaska Native
 Native Hawaiian or Pacific Islander Other _____

Are you able to safely drive yourself? Yes No Short distances only

Do you currently receive transportation through Family, Friends, Medicaid or other services?

- Yes (Please list which services) _____ No

How do you travel now to shop for groceries, travel to medical appointments, visit friends, etc.?

Do you live in an assisted living or apartment complex that offers transportation? Yes No

How do you plan to use this service? (*check all that apply*)

- Shopping Medical Social Connect to DART Work Other _____

My signature confirms that the information on this application is true and accurate to the best of my knowledge. I authorize a representative of Denton County Transportation Authority to contact the persons and authorities listed in this application to verify the information in determining my eligibility.

Applicant Signature: _____ Date: _____