JACKSON TRANSIT AUTHORITY

38 Eutah Street
Jackson, TN 38301

e-mail: info@ridejta.com
www.ridejta.com

In Association With TDOT, FTA & the City of Jackson

Dear Clients:

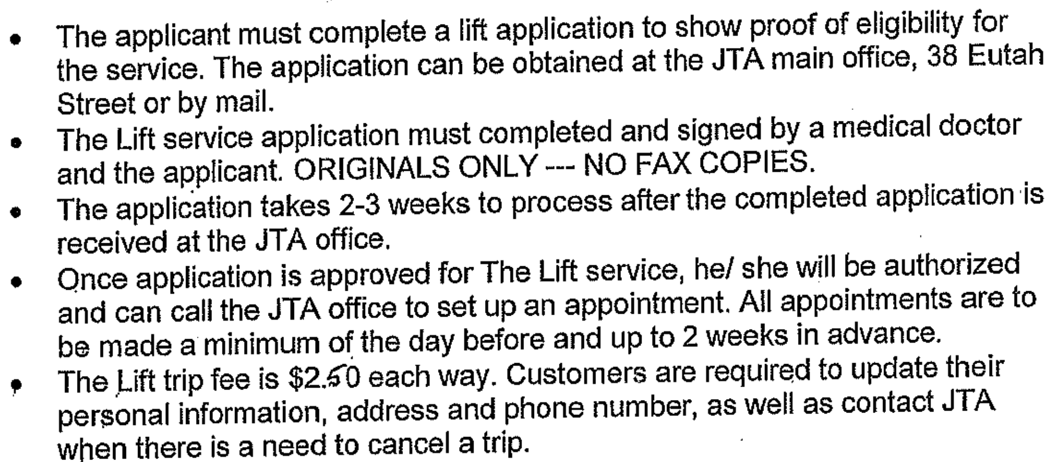
Below are the two ways transportation on "The Lift" can be authorized.

1. If a person **DOES HAVE** TennCare insurance, please contact his/ her insurance carrier who will set up the appointment for the client at the numbers listed below.

    - The insurance carrier will then fax over the information (client's name, appointment, time, and location of the Dr.'s office) to JTA.
    - The fax from the insurance carrier is JTA's authorization to provide the service. Without an authorization from a TennCare provider, JTA **CANNOT** provide service.
    - The following insurance carriers can be reached at:

TENNCARE SELECT or BLUECARE	1-866-473-7564
AMERICHOICE	1-866-405-0238
WINDSOR	1-615-782-7851

2. If applicant **DOES NOT** have the above TennCare:



    - The applicant must complete a lift application to show proof of eligibility for the service. The application can be obtained at the JTA main office, 38 Eutah Street or by mail.
    - The Lift service application must completed and signed by a medical doctor and the applicant. ORIGINALS ONLY --- NO FAX COPIES.
    - The application takes 2-3 weeks to process after the completed application is received at the JTA office.
    - Once application is approved for The Lift service, he/ she will be authorized and can call the JTA office to set up an appointment. All appointments are to be made a minimum of the day before and up to 2 weeks in advance.
    - The Lift trip fee is $2.50 each way. Customers are required to update their personal information, address and phone number, as well as contact JTA when there is a need to cancel a trip.

Thank you for your interest in Jackson Transit Authority (JTA) and the services it provides the residents of Jackson. If you have any questions about The Lift service or any JTA service, please contact the JTA office at (731) 423-0200, 8:00 a.m. – 5:00 p.m., Monday – Friday.

JACKSON TRANSIT AUTHORITY
38 EUTAH STREET * POST OFFICE BOX 102 * JACKSON, TN 38301

The Lift Program

Eligibility Criteria and Application Form Notice

The Lift service is specifically designed for those mobility impaired and those who are unable, without significant difficulty, to use the regular bus service. Service will be offered only to persons residing inside the city of Jackson and area served by the regular JTA buses.

Please note the following procedures that you and your Medical Doctor should follow while completing the following application.

1. Your doctor determines if you, the applicant, meets permanent or temporary criteria described in the Guide to Eligibility Criteria (last page). Note the section number, a complete listing is available for Medical Doctor upon request, and;
2. Your doctor must complete The Lift Application Form indicating the section number, and;
3. Specify the reason the applicant cannot use the regular route bus service, and;
4. Determine if the applicant requires an attendant while traveling and checks the appropriate space, and;
5. If disability is temporary, indicate the period of time applicant will be incapacitated.
6. When doctor, nurse, or agency is filling out form, please give office name, address, telephone number, and date of application.
7. Applicant must read and sign the Application Form on front and back.
8. Additional directions may be placed on back of application form.

JTA "THE LIFT" PROGRAM
38 Eutah Street, Jackson, TN 38301
(731) 423-0200

THE LIFT Application

1. Applicant's Name:____
(Last) (First) (Middle Initial)

2.Birthday__________

3.Applicant's address: ________________________________Apt. #_____Jackson, TN_______

4.Telephone number: Home: (731)__________________ Cell: (731) __________________

5. Gender: ☐Male ☐ Female

6. Nearest cross street: ______________________________

7. Person to contact, if other than applicant: _____________________

8.Telephone number:________________

9. Check the reason(s) why you are applying for the Lift:
☐ I can use regular Fixed Route buses to go some places, but not for other places.
☐ I can NEVER use a fixed route bus because (Explain briefly):

____

10(a). Please check which mobility aid you use:
☐ Cane
☐ Long White Cane
☐Crutches
☐Manual Wheelchair*
☐Electric Wheelchair*
☐Power Scooter
☐Walker
☐Leg Braces
☐Portable Medical Equip: Oxygen Tank
☐I do not use any of the mobility aids: I am Ambulatory.
☐Other:________________

Note: We may not be able to accommodate you if your wheelchair / scooter is too wide or too heavy to be safely lifted into and secured inside the vehicle.

10 (b). On your own, or if you use a mobility aid, how far can you travel?
☐ I cannot travel outside my house.
☐ I can get to the curb in front of my house.
☐ I cannot travel more than 200 feet.
☐ I can travel up to 3 blocks (1/4 mile).
☐ I can travel up to 6 blocks (1/2 mile).
☐I can travel up to 9 blocks (3/4 mile).

11. Do you require a personal care attendant (PCA) while traveling?
☐Yes ☐No

12. Do you currently use JTA fixed-route bus service?
☐Yes ☐No
If yes, which routes do you use?

____

13. When are you UNABLE to use the FTA fixed-route bus? (please indicate below which apply to you)
☐I can only wait at FTA bus stops if there is a bench or shelter.
☐The severity of my disability can change from day to day. I can ride the bus only when I am feeling good.
☐I cannot cross busy streets and intersections.
☐I have difficulty or cannot climb stairs and can only board a JTA bus if it has a lift or ramp.
☐ I have a health condition and cannot ride the bus if the walk is too far or if there is inclimate weather conditions.
☐I can never use the JTA fixed-route bus.

MEDICAL CERTIFICATION (to be completed by applicant's Medical Doctor)

14. Check all that apply to your patient's disabilities or symptoms that prevent them from riding JTA Fixed-route services:

General Medical Conditions	Neuromuscular Conditions	Vision/Hearing/Speech
☐ Cancer ☐ Diabetes ☐ Renal ☐ Organ Transplant ☐ Other:______________	☐Cerebral Palsy ☐ Brain Injury ☐ Multiple Sclerosis ☐ Muscular Dystrophy ☐ Paraplegia ☐ Parkinson's Disease ☐ Quadriplegia ☐ Spinal Bifida ☐ Stroke ☐ Vertigo/Dizziness ☐ Other:______________	☐ Aphasia ☐ Cataracts ☐ Glaucoma ☐ Diabetic Retinopathy ☐ Visual Field Deficit ☐ Visual Field Blindness ☐ Night Blindness ☐ Partially Blind ☐ Legally Blind (20/200 or worse) ☐ Totally Blind (no light perception) ☐ Deaf ☐ Deaf/Blind ☐ Other:______________
Heart and Circulatory Conditions	**Lung and Breathing Conditions**	**Bone and Joint Conditions**
☐ Angina ☐ Congestive Heart Failure ☐ Edema ☐ Heart Surgery ☐ High Blood Pressure ☐ Other:______________	☐ Allergies ☐ Asthma ☐ Cystic Fibrosis ☐ Emphysema ☐ Other:______________	☐ Amputation:______________ ☐ Broken Bone:______________ ☐ Arthritis ☐ Osteoarthritis ☐ Osteoporosis ☐ Other:______________

Cognitive/ Psychological
☐ Alzheimer's ☐Autism ☐ Dementia ☐ Mental Retardation ☐ Panic Disorder ☐ Schizophrenia ☐ Other: ______________

15. Is the disability ☐Temporary ☐ Permanent
16. If temporary, how long will services be needed:_______________

****Please review the medical information provided in the application and fill out the certification as is appropriate and sign the document. The information you provide will assist us in serving ONLY those who need Paratransit.***

Certification of Disability: (PLEASE PRINT CLEARLY AND LEGIBLE) must be licensed Physician.

I, (Name of Physician): ______________________________ certify
that ______________________________ (Name of Patient) to be a severely disabled person who has been a patient of mine since _______________ (Date)
and whose diagnosis
is ____
Please describe the physical and/or cognitive condition and how it functionally prevents the applicant from using fixed route bus service.

____

____

____

______________________________________ I also certify that the medical information provided in the application is accurate to the best of my knowledge and is consistent with the applicant's medical diagnosis.

17. ______________________
Medical Doctor's Name

18. ______________________
Medical Doctor's Signature

19. ______________________
Doctor's Office Phone Number

20. ______________________

____
Doctor's Office Name &Address

21. Date:___________ (Please use the reverse side of the application for additional information & Directions)

NOTE: THE LIFT service is for individuals who are unable to do one or more of the following:

- -Mobilize self to the nearest bus stop from his/her residence
- -Wait 5 minutes at the bus stop
- -Make decisions about money
- -Make decisions about getting off the bus
- -Mobilize self up to three blocks

APPLICANT VERIFICATION

22. I, ___________________________, agree to the release of this information to JTA THE LIFT Program for the purpose of THE LIFT Certification.

Applicant's signature is required here. This is to ensure the applicant understands he/she gives JTA the authority to ask their Medical Doctor (MD) questions about their mobility disability. JTA accepts marks made by the applicant if he/she is unable to sign the form, and also the signature of the applicant's representative (legal guardian and/or power of attorney).

USE OF INFORMATION

The use of the information provided herein intended for the sole purpose of establishing eligibility for THE LIFT Program. Information provided by applicant for certification will be treated as private and will not be released to any person, agency, institution or organization without the express permission of the applicant.

POLICY STATEMENT CONCERNING THE LIFT

-Notice is hereby given to all applicants for THE LIFT Program that the City of Jackson and the Jackson Transit Authority (JTA) do not discriminate in admission or access to, or treatment or employment in, its programs or activities on the basis of age, religion, race, color, sex, national origin, or disability.

-Any applicant for or user of transportation service provided by THE LIFT who feels that he/she has been discriminated against in the operation of THE LIFT or who is dissatisfied with the service provided by THE LIFT has the right to file a grievance with or make a complaint to the General Manager of JTA. A copy of THE LIFT Program grievance procedure is available to all applicants upon request.

-I agree that I will notify THE LIFT office at least one hour in advance if for any reason I cannot make my trip. I understand that failure to notify the office in the agreed time will be grounds for revoking my application and the right to participate in the program.

23. ____ ________________

Applicant's Signature Date

ADDITIONAL INFORMATION OR DIRECTIONS

____

____

FOR JTA USE ONLY

Date Application received: _____________ Reviewed by: ____________________ Approved by: __________

Other Action Taken: ____ Date: ____________________________

Date I.D. Card Issued: _______________________________________Certification number: _______________

38 Eutah ~~241 East Deaderick~~ Street
JTA LIFT PROGRAM
PO Box 102
Jackson, TN 38302-0102
(~~901~~ 731) 423-0209

GUIDE TO ELIGIBILITY CRITERIA

PHYSICAL DISABILITIES

SECTION 1	Non-Ambulatory Disabilities -- Wheelchair
SECTION 2	Mobility Aids -- Walker, cane, etc.
SECTION 3	Arthritis
SECTION 4	Amputation
SECTION 5	Cerebrovascular accident -- Stroke
SECTION 6	Pulmonary Ills
SECTION 7	Cardiac Ills
SECTION 8	Dialysis
SECTION 9	Sight Disabilities
SECTION 10	Hearing Disabilities
SECTION 11	Disabilities of Incoordination

DEVELOPMENT DISABILITIES

SECTION 12	Mental Retardation
SECTION 13	Cerebral Palsy
SECTION 14	Epilepsy
SECTION 15	Autism
SECTION 16	Neurological Handicap

MENTALLY DISORDERED DISABILITIES

SECTION 17	Emotionally Disturbed

ADDITIONAL DISORDERS

SECTION 18	Cancer
SECTION 19	Diabetic
SECTION 20	Other - Explain