Tri-City Roadrunner - Route Deviation – Registration Form

Name:						
LAST	LAST FIRST					
Prefer to be called: (i.e. Mrs. Smith, B	ob, etc.):					
Street address:						
City:	_ State: ZIP:					
Nearest cross street:						
Mailing address (if different from above	e):					
Home phone:	☐ Please check if this is a TDD line (for hearing impaired)					
Mobile phone:	Other:					
Emergency contact information:						
Who should we contact in case of em-	ergency or if we are unable to contact you at your regular number?					
(Family, friend, neighbor, caseworker,	etc.)					
Name:	Relationship:					
Home phone:	Mobile or other:					
Check appropriate box:						
☐ Age 60 or over (\$2.00 route	deviation total trip cost per one-way trip) *					
☐ Disabled (\$2.00 route devia	tion total trip cost per one-way trip) **					

^{*}If you are eligible for the discounted rate due to age, your registration form must be accompanied by a copy of your driver's license or photo identification.

^{**}If you are eligible for the discounted rate due to a disability, your registration form must also be accompanied a completed Disability Verification Form and Health Care Professional Certification.

REGISTRATION FORM (continued)

Mobility aids: Will yo	ou use an	/ mobility devices w	hen you ride Tri-City Roa	drunner?
	□NO	☐ YES - Please	e check all that apply (belo	ow)
☐ Manual wheelchair		Power wheelchair	☐ Power scooter	□ Walker
☐ Walking cane		White cane	☐ Crutches/braces	□ Oxygen
☐ Other:				
must fit within theYou must be ableMake sure that you	e secureme to contro our batter are not pe	ent area without blo I your power scoote y powered mobility rmitted to push you	ocking any portion of the is er or wheelchair.	our bus lifts and ramps and sle or exits. Irge to board and disembark
Do you use a persor	nal care a	ttendant (PCA)?		
□ NO □ YES				
	e duration	of your trip. If you		at the time of boarding and at you are unable to control
Do you use a service	e animal?			
□ NO □ YES -	· please de	escribe what type o	f animal and for what purp	oose it was trained.
safety regulations. If	the anima nimal may	al acts out of contr be removed from	ol or causes a major dist the bus and turned ove	s and abides by local anima curbance to the environmen r to the local animal contro
Tri-City Roadrunner	POLICIES	S & GUIDELINES /	ACKNOWLEDGEMENT F	RECEIPT:
Signed by Curb-to-Cu	rh Annlics	nt	Date	

DISABILITY VERIFICATION

Name:								
	LAST		FIRST					
Alternative	formats:	Do you	need info	rmation pro	ovided in	an alternative	format?	
□ NO		YES	-	please	indicate	format	type:	
Is the disab	ility:							
☐ Permane	nt 🗆 T	emporary, I e	expect it to la	st until				
☐ I don't kn	ow							
□ NO □ NO □ I hereby cer	tify that, to the	- please do	escribe the	type of a	given in this a	at person will pplication is corty Roadrunner.		
Signature of	applicant:				Date:			
If someone provided:	other than th	e applicant	completed t	his application	on, the follow	ving information	must be	
Name of per	son completing	g application:						
Relation to a	applicant:			_ Phon	e:			
Signature of	person comple	eting form:						

HEALTHCARE PROFESSIONAL CERTIFICATION

Disability verifica	ation for:					
Client name						
1. Is the applicant currently your patient?						
	☐ YES	□NO				
2. Does	Does the applicant have a functional or cognitive disability that can be documented?					
	☐ YES	□NO				
3. To the be	est of your knowledg	e, does your patient re	equire a personal car	e attendant?		
	☐ YES	□NO				
I hereby certify this information true and correct to the best of my knowledge.						
Health Care Professional Signature: Date:						
Health Care Pro	fessional Printed Na	me:				
Health Care Pro	fessional License Nu	umber:				
Health Care Fac	cility Name:					
Address:		City:	State:	ZIP		
Phone:		Fax: _				
You may submit	at the address below	w by email or mail this	form to:			
Organization: Tr Address: 1825 1 City: Gering St	ate: NE Zip: 69341 adrunner@scottsbluf					