

**COUNCIL BLUFFS  
SPECIAL TRANSIT SERVICE  
209 PEARL STREET  
COUNCIL BLUFFS, IOWA**

**Application for STS Service**

**Part 1. To be completed by Applicant (please type or print)**

In order to be eligible for STS services, one of the conditions stated below must be present. Please check the condition/situation that applies.

\_\_\_\_\_ Due to my disability, I cannot board, ride or disembark MAT accessible, lift equipped bus service without the assistance of another individual.

\_\_\_\_\_ I am capable of using the MAT accessible, lift equipped bus service. However, the route I need to utilize is not at present accessible.

\_\_\_\_\_ I am capable of using the MAT accessible, lift equipped bus service. However, due to my disability, I am prevented from getting to and from the stop. (Note- the fact that it may be more difficult, or inconvenient, does not form the basis of eligibility. The inability to get to a stop must prevent the desired travel in order to qualify)

Name: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
                    Last                      First                      Middle                      Social Security #

Address: \_\_\_\_\_ Council Bluffs, IA \_\_\_\_\_  
  Street    Zip

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Birth Date: MO \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

I require a Personal Care Attendant Yes \_\_\_\_\_ No \_\_\_\_\_

Mobility Aids (check one)

\_\_\_\_\_ Wheelchair                                      \_\_\_\_\_ Temporary

\_\_\_\_\_ Cane, crutches, walker, etc                      \_\_\_\_\_ None of the above

Applicant's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Approved: \_\_\_\_\_ Date: \_\_\_\_\_  
                    (STS office)

**Part II: Physician's Statement (Please Type or Print)**  
**This Section Must be Completed by a Licensed Physician**

Application is subject to review/approval by Council Bluffs Medical Review Officer

I have examined the individual who is submitting this application and attest that he/she is eligible for STS service due to the condition indicated by the applicant. I have indicated below the qualifying disability/disabilities. (Please check as many as apply.)

- 1. The person is under 65 years of age and possesses a Medicare Card. (State nature of disability on line 9 below.)
- 2. The person has a condition which requires the use of walkers, crutches, wheelchairs, leg or foot braces, or other such devices to aid in mobility.
- 3. The person has one or more missing limbs or critical parts thereof. Or, uses prosthetic devices which renders the person incapable of boarding or deboarding a standard transit bus.
- 4. The person has a cardiovascular or respiratory condition.
- 5. The person has a neurological condition that significantly interferes with coordination, strength, or endurance such as polio, cerebral palsy, head injury, multiple sclerosis or paralysis.
- 6. The person has a musculo-skeletal condition which significantly impairs motor skills, such as muscular dystrophy, severe rheumatism or severe arthritis, affecting two or more limbs. American Rheumatism Association criteria may be used as a guideline for the determination of arthritic handicap. Therapeutic Grade II or worse are evidence of arthritic handicap.
- 7. Return trips from dialysis treatments.
- 8. The person has Epilepsy. Clinical disorder involves impairment of consciousness characterized by major motor seizures (grand mal or psychomotor) sustained by EEG, occurring more frequently than once a month, in spite of prescribed treatment. With: a) Diurnal episodes or, b) Nocturnal episodes which show residual interfering with activity during the day.
- 9. Other - State nature of disability. \_\_\_\_\_  
\_\_\_\_\_
- 10. The person does not have the cognitive ability to follow directions or remember, thereby constituting a transportation disability.
- 11. The person has a temporary disability (lasting no more than 12 months) which can be expected to last until - Month \_\_\_\_\_ Year \_\_\_\_\_. State nature of disability:  
\_\_\_\_\_

Physician's Name: \_\_\_\_\_  
Last First Middle Medical Lic. #

Physician's Address: \_\_\_\_\_  
Street City State Zipcode

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_