HARNETT COUNTY TRANSIT
250 Alexander Drive, PO Box 85 Lillington, NC 27546
910-814-4019 (PHONE) 910-814-4020 (FAX)

Harnett COUNTY NORTH CAROLINA

TTY FOR HEARING OR SPEECH IMPAIRMENTS DIAL 1-800-799-4889

Application for Elderly and Disabled Transportation Assistance Program

WHO IS ELIGIBLE?
Residents of Harnett County age 60 and older and residents no matter what age who have a certifiable mental or physical disability, which substantially limits one or more major life activity. Residents who are determined to be eligible for the program may receive transportation based on availability of system resources.

Elderly: Harnett County resident 60 years of age or older.

Disabled: Harnett County resident, one who has a physical or mental impairment that substantially limits one or more major life functions and has record of such impairment, or who is regarded as having such an impairment.

Harnett County Resident: Must live and have their mailing and residential address in Harnett County.

WHAT TO DO?
Please fill out application ***completely***.
Please have your physician or a medical professional, or social worker sign on behalf of this applicant

Last Name: _____ First Name: _____ M.I.: _____

Address: _____ City: _____ State: _____ Zip: _____

Mailing Address (if different from above): _____

Telephone: _____ Email: _____

Social Security Number: _____ Date of Birth: _____

1. Do you live alone? (Please check) _____ Yes _____No
2. Do you have a driver's license? (Please check) _____Yes _____No
3. Do you own an automobile? (Please check) _____Yes _____No
4. Do you own your own home? (Please check) _____Yes _____No
5. Why do you need transportation? (Explain) _____

   _____
6. Do you receive Medicaid? (Blue Card) _____ Yes _____ No
7. Are you served by any of the following agencies? (Check all that apply)

   Department of Social Services: _____
   Dialysis: _____
   Substance Abuse: _____
   Hospice: _____
   Cancer Center: _____
   Health Department: _____
   Mental Health: _____
   Vocational Rehabilitation: _____
   Work First: _____
   Cardiopulmonary Rehab: ____

8. List any other agencies from which you receive service: _____

_____

9. If you are disabled, what is the nature of your disability? (Check all that apply)

_____Mental _____ Physical _____ Vision _____Hearing _____Other

13. List the names and locations of each medical facility you visit on a regular basis: _____

_____

_____

14. Please give detailed directions to your home: _____

_____

_____

Your Signature: **X**_____ Date: _____

CERTIFICATION BY A MEDICAL PROFESSIONAL, PHYSICIAN OR SOCIAL WORKER IS REQUIRED OF ALL PERSONS MAKING APPLICATION FOR SERVICE.

_____ (PLEASE PRINT) DO HEREBY CERTIFY THAT THE APPLICANT HAS A PHYSICAL OR MENTAL IMPAIRMENT THAT SUBSTANTIALLY LIMITS ONE OR MORE MAJOR LIFE ACTIVITY OR IS AN INDIVIDUAL WHO HAS A RECORD OF SUCH IMPAIRMENT, OR IS AN INDIVIDUAL WHO IS REGARDED AS HAVING SUCH IMPAIRMENT.

SIGNED X_____ DATE_____

Physician, Medical Professional, Social Worker

Provisions of services under this program are subject to change based on availability of funding, equipment and personnel.