GoGeo provides Limited Paratransit Service to eligible people living in or visiting the City of Georgetown. This service provides rides, from origin to destination, within the city limits of Georgetown. GoGeo Limited Paratransit Service is operated by the Capital Area Rural Transportation System (CARTS) through a contract with Capital Metropolitan Transportation Authority (Capital Metro).

Transportation services are accessed by completing this application and being certified through CARTS, or if you are visiting from another area, by providing documentation of ADA certification from a transportation service in another area of the country.

Who should apply for Limited Paratransit Services?

- People with mobility impairments due to visual limitations, arthritis, spinal cord injury, or other physical and/or cognitive limitations.

How to Apply:

- Complete this application and sign the Applicant Agreement/Release of Information section.
- Have your doctor, rehabilitation specialist, or other qualified health care provider complete and sign the professional verification section.
- Send the completed application to:

  GoGeo c/o CARTS  
  338 S. Guadalupe St.  
  San Marcos, TX 78666  
  Fax: 512-805-0001

If you need an alternative format of this application or additional information, please contact us at 512-505-5661 or email GoGeo@ridecarts.com.
If you have a disability, you may be eligible for GoGeo Limited Paratransit Service. The information obtained in this certification process will be used to determine your eligibility.

This application must be filled out completely, including the verification of eligibility by a qualified professional. Incomplete applications will be returned to applicants.

Step 1: Complete the General Information Section

NAME:
Last__________________________________First___________________________________MI_________

ADDRESS:
Street________________________________City________________________________State______Zip_________

PHONE:
Home_________________________Work_________________________Cell_________________________

DATE OF BIRTH:
_____/_____/

EMERGENCY CONTACT:
NAME:__________________________________________PHONE #:_________________________________
ADDRESS:__________________________________________________________________________________

Step 2: Information about your disability

If you answer “NO” or “SOMETIMES” to any of these questions, you must explain your answer in the space provided.

1. Can you board the bus by yourself?
   _____YES _____NO _____SOMETIMES_____
   _______________________________________________________________________________________

2. Are you able to climb three 12-inch steps without assistance?
   _____YES _____NO _____SOMETIMES_____
   _______________________________________________________________________________________

3. If you have a cognitive disability, are you able to give your name, address, and telephone number upon request?
   _____YES _____NO _____SOMETIMES_____
   _______________________________________________________________________________________

4. Are you able to recognize your destination or landmark?
   _____YES _____NO _____SOMETIMES_____
   _______________________________________________________________________________________

5. Are you able to deal with unexpected situations or unexpected changes in routine?
   _____YES _____NO _____SOMETIMES_____
   _______________________________________________________________________________________
Are you able to ask for, understand, and follow directions?

____YES ____NO ____SOMETIMES____

___________________________________________________________

Are you able to safely and effectively travel through crowded and/or complex facilities?

____YES ____NO ____SOMETIMES____

___________________________________________________________

If you are visually impaired, have you received mobility training from another organization such as Texas Department of Assistance and Rehabilitative Services or ARCIL? ____YES ____NO

Do you use any of the following assistive devices? (Check all that apply)

____Manual wheelchair—passenger is able to transfer to a seat
____Passenger is not able to transfer to a seat without assistance
____High Wheelchair       ____Long Wheelchair     ____Electric Wheelchair
____Power Scooter         ____Walker (foldable)    ____Cane
____Crutches             ____Guide Dog           ____Oxygen
APPLICANT AGREEMENT AND RELEASE

I agree that, if I am certified for GoGeo Limited Paratransit Service, I will pay the exact fare, if required, for each trip. I agree to notify the office of any changes in my status which may affect my eligibility to use the service. I also understand that failure to adhere to the policies and procedures will be grounds for revoking my application and the right to participate in the program.

I understand and agree to hold GoGeo harmless against all claims or liability for damages to any person, property, or personal injury occurring as a result of my failure to equip or maintain the safety of the adaptive equipment or certified guide/service animal that I require for mobility. I have read and fully understand the conditions for service outlined in the Rider’s Guide and agree to abide by them.

I hereby authorize the release of verification of information and any additional information to GoGeo for the purpose of evaluating my eligibility to participate in the Program.

I certify that the information provided in this application is true and correct.

__________________________________                                                                       ____________________
                           Signature                                        Date

If someone assisted you in completing this application, please provide their information and their signature below.

NAME:______________________________________ DAYTIME PHONE #:____________________________

ADDRESS:
Street_________________________________________Apt. #__

City_________________________________________State____________Zip__________

__________________________________                                                                       ____________________
                           Signature                                        Date

An Eligibility Specialist will review your application and may ask you additional questions. You may also be required to participate in an assessment in the community so we can further evaluate your functional abilities.
Health Care Professional Verification of Eligibility

ALL INFORMATION FOR VERIFICATION OF ELIGIBILITY MUST BE FILLED IN BY A QUALIFIED HEALTH CARE PROFESSIONAL.

PERSON COMPLETING VERIFICATION:_____________________________________________________________________________

PROFESSIONAL TITLE: _______________________________________________________________________

AGENCY AFFILIATION: _______________________________________________________________________

STATE OF TEXAS CERTIFICATION ID#____________________________________________________________

BUSINESS ADDRESS:  ________________________________________________________________________
_________________________________________________________________________________________
Street                                                                                     Ste. #
_________________________________________________________________________________________
City                                                                                        State                                                                                        Zip
BUSINESS PHONE NUMBER __________________________________________________________________

What is the medical diagnosis that causes the disability?
_________________________________________________________________________________________

Is this condition:  Temporary_____   Permanent_____  

If temporary, what is the expected duration?____________________________________________________

Dates of Duration

I verify that the information provided above for verification is true and correct to the best of my knowledge.

_________________________________________________________________________________________________________
Signature of Qualified Professional  Date