ADA APPLICATION

Dear Applicant,

Transit agencies, such as PARTA, take steps to make fixed route bus services accessible to persons with disabilities. Fixed route bus service is intended to be the primary mode of public transportation for persons with disabilities.

PARTA's ADA service is a door-to-door, shared ride service that is made available to persons with disabilities that cannot use accessible local fixed route services as required by the Americans with Disabilities Act. The service area encompasses ¾ mile area around the local fixed routes. ADA regulations require individuals must apply for and be determined eligible in order to receive Paratransit Services.

To apply for PARTA's ADA services, complete the following application and have the Medical Verification Form completed by a physician licensed for your condition. Eligibility may be permanent or temporary, depending on the disability. Some individuals may be eligible only for certain trips or may qualify only during certain times of the year. Your application must be submitted in full before it can be processed.

After your application is received, you will be contacted by phone to arrange an in-person assessment. Transportation to this interview is free if you would like to use a PARTA vehicle. The purpose of this assessment is to review your application with you, determine your eligibility and assess any mobility device you may need to utilize for transportation at that time. Once all necessary information is gathered you will be notified in writing within 21 calendar days by mail of your eligibility status.

If you have any questions or need assistance completing this form, please call:

PARTA: 330-678-1287
TTY: 330-676-5100

You must complete this form in its entirety to be considered for PARTA's ADA services. Please let us know if you have any questions or need assistance.

Revised January 2020

ADA Paratransit Application

Personal Information			
First Name:	MI:	Last Name:	
Home Phone:	Cell Phone:	Email Address:	
Street Address: (include Apt. Name & Number/Lot Number)		City:	ZIP Code:
Mailing Address (if different from above)			
Street Address:		City:	Zip Code:
Emergency Contact Information			
Emergency Contact:		Home Phone:	
Cell Phone:		Relationship:	
Benefits Information			
Are you a Medicaid Recipient? ☐ Yes ☐ No			
Do you Receive Medicare/ Social Security Disability Insurance (SSDI)/ Suplemental Security Income (SSI)? ☐ Yes ☐ No			
Do you receive Veterans Administration (V.A.) Disability at a Miniumum of 70% ☐ Yes ☐ No			

Information on completing ADA Application

All of the information provided below will be used solely for the purpose of determining your eligibility and any special assistance you may need when using ADA Paratransit Service. PARTA will strictly limit ADA trips to persons required to be eligible under ADA law. Individuals with permanent or temporary disabilities may be eligible for service unconditionally or with respect to a particular type of trip or under particular conditions, depending on the assessment outcome, even when the fixed route is completely accessible. Transit services for persons with disabilities will largely be provided by fixed route services.

I authorize _____ (insert name of medical professional) to release to PARTA information about my disability and health condition and the effect on my ability to travel on PARTA buses. I understand that I may revoke this authorization at any time. All medical information, which you or your health care professional provide, will be kept confidential to the extent permitted under the law except that the information may be shared with other professionals or agencies involved in the determination of your eligibility.

_____ _____

Signature Date

Disability and Health Condition Information

1. What is the nature of your disability?

_____

_____

2. Does this prevent you from using the fixed route services?
   ☐ Yes ☐ No If yes, please explain.

_____

_____

3. Is your disability considered permanent? ☐ Yes ☐ No
   If no, how long do you expect to have this disability?

_____

4. Does your disability change from day-to-day or seasonally? ☐ Yes ☐ No
   If yes, please explain:

_____

_____

Mobility Information

5. Do you currently use any mobility aids or specialized equipment? ☐ Yes ☐ No
   If yes, please select all that apply:

☐ Brace	☐ Manual Wheelchair	☐ Communications Board
☐ Crutches	☐ Motorized Wheelchair	☐ Service Animal
☐ Scooter	☐ Portable Oxygen	☐ Support Cane
☐ Walker	☐ Hearing Aid	☐ Prosthesis

   ☐ Other (please specify):_____

6. If you currently utilize a wheelchair or scooter, will you be willing to utilize PARTA's 4-point tie-down system if necessary to property secure your mobility device? ☐Yes ☐ No ☐ N/A

Current Travel Information

7. Have you used or do you currently use, PARTA's fixed route bus service? ☐ Yes ☐No

8. Do you require a Personal Care Attendant to ride with you? ☐ Yes ☐ No
   If yes, what assistance does that person provide for you?

_____

_____

9. How many blocks are from your residence to the nearest bus stop?

☐ Less than 2 blocks ☐ 2 to 4 blocks ☐ Not sure

☐ 5 to 7 blocks ☐ More than 7 blocks

10. Can you get to the nearest bus stop by yourself? ☐ Yes ☐ No
    If no, explain why not?

    _____

    _____

11. Not all stops have seating or shelters. Considering the possibility of needing to stand or wait at a bus stop, how long would you be able to stand at a stop?

☐ 0 minutes ☐ 5 minutes ☐ 10 minute ☐ 15 minutes ☐ Longer than 15 minutes

Other: _____

12. All fixed route buses have equipment that lowers the front end of the vehicles to enable rolling a mobility device on or walking on without having to step up. Would this make using the fixed route easier? ☐ Yes ☐ No

13. Does the weather affect your ability to use the fixed route system? ☐ Yes ☐ No

14. List your three (3) most frequent destinations you travel and how you get there.

	Location 1	Location 2	Location 3
Destination Name			
Address			
How frequently do you travel there? (within a month)			
How do you currently get there?			

Medical Verification Form

This form shall be completed by a physician licensed to diagnose your condition or disability and is able to provide the needed information that would help determine eligibility for ADA Paratransit Service. We currently only accept signatures from a D.O., M.D. or N.P (nurse practitioner). Incomplete forms will be returned.

Patient Information			
Patient First Name:	MI:	Patient Last Name:	
Physician Information			
Physician First Name:	Physician Last Name:	Title (D.O., M.D., N.P.):	
Name of Practice:		Medical License No.:	
Street Address:	City:	ZIP Code:	

Disability Description	
Nature of Disability: ☐ Physical ☐ Cognitive	Is the condition: ☐ Permanent ☐ Temporary Temporary Condition Duration: _____

Cognitive/Neurological:	Physical Health:
☐ Cerebral Vascular Accident (Stroke) ☐ Neurological Handicap ☐ Dementia ☐ Alzheimer's ☐ Developmental Disability ☐ Autism: ☐ Moderate ☐ Severe ☐ Profound ☐ Mental Illness ☐ Cerebral Palsy ☐ Other: _____	☐ Impaired or assisted ambulation ☐ Pulmonary; Portable Oxygen Tank? ☐ Yes ☐ No ☐ Cardiac ☐ Seizures ☐ Kidney Disease ☐ Arthritis, specify: _____ ☐ Other: _____
Sensory:	Other/Not Listed
☐ Legally Blind ☐ Severely Visually Impaired ☐ Deaf ☐ Hard of Hearing ☐ Other _____	☐ Other, specify: _____

Please describe how the severity of all conditions marked above functionally prevents the applicant from using PARTA's fixed route ADA equipped buses.

_____

_____

_____

_____

I certify that, based upon my skill, knowledge and experience, and a reasonable degree of certainty, the above named applicant is physically or cognitively unable to travel to and from stops to use regular fixed-route transportation. Please initial the following statements. Applicant will not be eligible to travel with a PCA unless you initial the corresponding line certifying need.*

_____ I am familiar with the Applicant and his/her disability and health condition.

_____ I certify that I have read and agree with the Applicant's information in its entirety.

_____ I certify that the Applicant requires the assistance of a Personal Care Attendant to travel.

Signature: _____ Date: ____/____/_____