



# ADA Paratransit Application

## **SECTION 1: GENERAL INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

Apt. Complex Name: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (home) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Email Address (Required): \_\_\_\_\_

Are you currently a BCRTA rider? \_\_\_\_\_ YES \_\_\_\_\_ NO

Please list two emergency contacts:

Name \_\_\_\_\_

Home or cell Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Home or cell number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Relationship: \_\_\_\_\_

Closest bus route to my address ([www.butlercountyrta.com](http://www.butlercountyrta.com)): \_\_\_\_\_

Do you have a personal care attendant (PCA) who assists you with daily life functions?

\_\_\_\_\_ Yes \_\_\_\_\_ No

All information regarding BCRTA is provided in writing unless otherwise specified. Do you need information given to you in another form?

If yes, what form?

\_\_\_\_\_

Did you need help completing this form? \_\_\_\_\_ Yes \_\_\_\_\_ No

If you answered yes, please complete the following information about the person who helped you.

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Agency name (if professional): \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt# \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## **SECTION 2: APPLICANT'S ABILITY TO USE FIXED ROUTE BUS SERVICE**

Please read the following statements and mark all those that describe your ability to use the fixed route bus.

\_\_\_\_\_ I have a **temporary** disability which prevents me from getting to the bus stop. I will need BCRTA service until I recover.

\_\_\_\_\_ I have an **ambulatory** disability which prevents me from boarding a bus even with a wheelchair lift without assistance.

\_\_\_\_\_ I cannot get to the bus stop by myself.

\_\_\_\_\_ I have a **cognitive disability** which prevents me from remembering and/or understanding how to find my way to and from the bus stop.

\_\_\_\_\_ I have a **visual disability** that prevents me from finding my way to and from the bus stop.

\_\_\_\_\_ I have a **severe medical condition**. My condition results in an impairment that makes it impossible for me to use the fixed route system.

\_\_\_\_\_ I have a **disability that comes and goes**, I can use the fixed route system on days when I am feeling well, but on bad days, I can't make it to the bus stop or get on the bus.

**In your own words, please explain why you cannot use the fixed route bus service.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION 3: INFORMATION ABOUT YOUR CURRENT USE OF THE FIXED ROUTE BUS SYSTEM.**

1. Do you currently use the fixed route bus:  Yes  No
2. When was the last time you used the fixed route bus? \_\_\_\_\_
3. Did you use any type of mobility aid or life support equipment? \_\_\_\_\_

If yes, describe:

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4. How far can you travel by foot or using a mobility aid? Check all that apply

To the ground outside my home  Can  Cannot

To the curb in front of my home  Can  Cannot

Up to ¼ mile  Can  Cannot

Up to ½ mile  Can  Cannot

Up to ¾ mile  Can  Cannot

5. Can you wait up to 15 minutes at a bus stop?  Yes  No

If no, please explain:

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6. Can you get on and off a fixed route bus:

Yes  No  Sometimes  I don't know  I have never tried

If you chose NO or SOMETIMES, check all that apply:

Only if the bus has a wheelchair lift  I cannot climb the stairs

I don't want to use the lift  Other, explain:

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7. If you are able to get on and off a fixed route bus, can you get to a seat or wheelchair position by yourself?  Yes  No  Sometimes

If you chose NO or SOMETIMES, check all that apply:

I need someone to help me  I need a seat nearest the door

I have a balance problem  I have trouble finding a seat

Other, explain:

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**SECTION 4: INFORMATION ABOUT YOUR DISABILITY AND MOBILITY EQUIPMENT**

1. What types(s) of disability(ies) prevent you from using the fixed route bus? Check all that apply.

- Physical disability  Visual impairment/blindness  
 Developmental or Cognitive disability  Mental Disorder  
 Health related condition  
 Other, explain:

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2. My disability is:  Permanent  Temporary  I don't know

If temporary, I expect it to last for another \_\_\_\_\_ months.

3. Check all the mobility aids or equipment you use or might use while riding a BCRTA vehicle:

- Cane  Long White Cane  Leg braces  Crutches  
 Communication board  Walker  Manual wheelchair  
 Powered wheelchair  Power scooter  Life support equipment  
 Service animal

All BCRTA Vehicles are equipped with lifts, ramps and securement stations and are compliant with all ADA regulations. Regulation No. 49 CFR Part 38 requiring that lifts have a minimum design load of 600 pounds and that the lift platform accommodate a wheelchair measuring 30 inches by 48 inches.

**SECTION 5: THE ENVIROMENT AROUND YOUR HOME TO THE CLOSEST BUS STOP**

1. In your own words, describe the terrain between where you live and the closest bus stop. Describe: sidewalks, visibility, roadway traffic, temporary construction, traffic signals, curbs, or anything else you think is noteworthy:

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2. Are there sidewalks outside your home?  Yes  No

3. How many steps are there at the entrance to your home: \_\_\_\_\_

**SECTION 6: YOUR CURRENT TRAVEL NEEDS**

1. Currently, how do you travel to the places you need to go outside your home?

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2. List two or three of your most frequent travel destinations:

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**SECTION 7: TRAVEL TRAINING**

Travel training is a personalized (individual or group) instruction that teaches the skills necessary to use fixed route BCRTA bus system and BGo. Please see attached flyer for more information on this optional program.

1. Have you ever received travel training:  Yes  No

If yes, who provided the training?

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2. Would you be interested in receiving information about this service?

Yes  No

If you checked no, please explain why you are not interested in travel training?

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**SECTION 8: APPLICANT'S CERTIFICATION**

In compliance with the Americans with Disabilities Act of 1990 (ADA), BCRTA provides paratransit service (other than the regular bus service) to anyone with a disability, who qualifies and who cannot use the fixed route bus system and who is traveling within 3/4 mile of a scheduled fixed route. This shared-ride service is intended only for those trips that the rider cannot make on the fixed route system. This application is intended to determine when and under what circumstances that applicant can use the shared-ride ADA Paratransit service.

I understand that the purpose of this application is to determine if there are times when I cannot use the fixed route or BGo bus system and will need to use the shared-ride Paratransit system. I understand that all the information concerning my disability will be kept confidential and shared only with professionals that will be involved in the determination of my eligibility. I certify that, to the best of my knowledge, all the information in this application is true and correct. I authorize any professional organization and/or agency listed in this application to release information relating to my disability to the ADA office in order to determine eligibility.

Applicant's signature: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of applicant's parent, legal guardian, or PCA if applicable:

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# Clinical Professional Authorization

**This form to be completed by a Clinical Professional: This cannot be the only determination of eligibility.**

Examples: Licensed physicians, Orientation and mobility specialists, therapist, clinical social workers, and registered nurses.

To the Professional completing this form: The individual presenting this form to you is applying for Paratransit services. Paratransit service is a federally mandated ADA (American with Disabilities Act) door to door shared-ride specially equipped van ride service for people whose disability **prevents** them from using the regular bus transit system under certain circumstances or all the time. Only professionals who have knowledge of the applicant's functional ability or limitations to use the regular transit system should complete this form. **If a person has the functional capability to use the BCRTA fixed route buses, that person is NOT eligible for paratransit services. Disability alone and distance to and from a bus stop, by itself, do not qualify a person for paratransit services.** Please assist us in determining this individual's true eligibility for the use of the Paratransit service. Please feel free to attach any additional information you think will help with the determination process.

Applicant's Name: \_\_\_\_\_

I have known the applicant since \_\_\_\_\_ (year)

Please list the diagnosis(es)

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1. The applicant has a Functional Disability: \_\_\_\_ Yes \_\_\_\_ No  
If yes, is the applicant able to?  
Get to the curb by foot or mobility device without assistance?  
\_\_\_\_ Yes \_\_\_\_ No  
Board or disembark a transit vehicle by using the stairs or a lift?  
\_\_\_\_ Yes \_\_\_\_ No  
Find and occupy a seat (if not using a wheelchair or scooter) for the trip?  
\_\_\_\_ Yes \_\_\_\_ No  
Safely stand while riding the bus if a seat is not available? Or can stand while holding on?  
\_\_\_\_ Yes \_\_\_\_ No
2. The applicant has a Sensory or Cognitive Disability \_\_\_\_ Yes \_\_\_\_ No  
If yes, is the applicant able to?  
Communicate addresses, destinations and telephone numbers upon request?  
\_\_\_\_ Yes \_\_\_\_ No  
  
Ask for, understand and follow directions?

\_\_\_\_\_ Yes \_\_\_\_\_ No

Recognize a destination or landmark?

\_\_\_\_\_ Yes \_\_\_\_\_ No

Deal with unexpected situations and/or changes in routine?

\_\_\_\_\_ Yes \_\_\_\_\_ No

Safely and effectively, travel through crowded and/or complex facilities?

\_\_\_\_\_ Yes \_\_\_\_\_ No

3. Does the applicant have a visual disability? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, please describe how the condition would limit the applicant's ability to use the regular transit system.

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4. Does the applicant have a DSM IV diagnosis? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, describe how the condition would limit the applicants' ability to use the regular transit system

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5. Is this disability(ies) temporary? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, how long? \_\_\_\_\_  
6. Are there any other concerns about this applicants' ability to use the regular transit system?

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7. In your clinical opinion, can the applicant use a fixed route bus? (All BCRTA buses are 100% accessible)

\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Sometimes

Print your name: \_\_\_\_\_ Title: \_\_\_\_\_

Office address: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax: \_\_\_\_\_

License number: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Please return your completed application and a copy of a PHOTO ID to:**

Butler County Regional Transit Authority

3045 Moser Ct.

Hamilton, Ohio 45011

Fax: - 513.785.5227

**Questions about the application please contact:**

513.785.5237

[www.butlercountyrta.com](http://www.butlercountyrta.com)