ADA Paratransit Application

Please be sure to respond to ALL questions/sections.
Incomplete applications may take longer to process or may be returned.

SECTION 1: GENERAL INFORMATION

Last Name: _____ First Name: _____

Street Address: _____ Apt #: _____

Apt. Complex Name: _____

City: _____ State: _____ Zip Code: _____

Phone: (home) _____-_____-_____ Cell: _____-_____-_____

Email Address (Required): _____

Please list two emergency contacts:
Name: _____ Email: _____

Home or cell Phone: _____-_____-_____ Work number: _____-_____-_____

Relationship: _____

Name: _____ Email: _____

Home or Cell Phone: _____-_____-_____ Work number: _____-_____-_____

Relationship: _____

How do you prefer to receive information regarding your ride? Text or Phone call.
Are you currently a BCRTA rider? ☐ Yes ☐ No

Do you use a personal care attendant (PCA) who assists you with daily life functions?
☐ Yes ☐ No

If yes, how does your PCA assist you, such as getting to your destination or with activities?

_____

Do you travel with a Personal Care Assistant? ☐ Yes ☐ No

Closest bus route to my address (www.butlercountyrta.com): _____

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: _____

Fixed Routes are buses that have designated stops along specific routes on a set schedule.

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.

Describe your specific disability/impairment and how it prevents you from riding the fixed route system:

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:

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:

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:

SECTION 4: INFORMATION ABOUT YOUR DISABILITY AND MOBILITY EQUIPMENT

1. What type(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:

_____

_____

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 accommodates a wheelchair measuring 30 inches by 48 inches.

SECTION 5: 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?

   _____

2. Would you be interested in receiving information about this service?
   ☐ Yes ☐ No

SECTION 6: 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 ¾ 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 torelease information relating to my disability to the ADA office in order to determine eligibility.

Applicant's signature: _____ DOB: _____

Date: _____

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

_____

Have you answered all the questions and provided explanations where required?
INCOMPLETE APPLICATIONS WILL BE RETURNED.
Complete applications will be processed within 21 days after it has been received.

Clinical Professional Authorization

This form is 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.

These questions/sections must be completed, or the application will not be considered.

Applicant's Name: _____
I have known the applicant since _____ (year)
Please list the applicant's specific disability or impairment:

_____

_____

Please explain how the applicant's disability or impairment limits one or more major life activities impacting their ability to use fixed route transportation:

_____

_____

_____

Does the applicant experience anxiety or panic attacks in closed places, crowded places, or unfamiliar places? ☐ Yes ☐ No

If yes, please explain _____

_____

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.

   _____
   _____
   _____
   _____

4. Does the applicant have a DSM IV diagnosis? ☐ Yes ☐ No
   (Please do not use codes)

   If yes, describe how the condition would limit the applicants' ability to use the regular transit system.

   _____
   _____

   Is this disability(ies) temporary? ☐ Yes ☐ No
   If yes, how long? _____

5. **Fixed routes** require the applicant to navigate to a bus stop, board the bus, locate a seat, and disembark the vehicle. In your clinical opinion, you certify the above applicant's functional disability **prevents** the applicant from utilizing the fixed route system.

☐ Yes ☐ No ☐ Sometimes (please explain)

_____

_____

Is there any other aspect of this person's disability that precludes this individual from successfully using the **fixed route** bus system? If yes, please explain.

_____

_____

Would this person be capable of learning how to cope with and navigate the fixed route system with one-on-one travel training? ☐ Yes ☐ No

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

6 S. 2nd Street Suite 600

Hamilton, Ohio 45011

Fax: - 513.785.5227

Email - request@butlercountyrta.com

Questions about the application please contact:

513.785.5237

www.butlercountyrta.com