ADA Paratransit Application

TEMPORARY ELIGIBILITY REQUEST

Bcrta
Butler County Regional Transit Authority

Please be sure to respond to ALL questions/sections.
Use this form if you are requesting service for a duration of six months or less.

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 ONE emergency contact:

Name: _____ Email: _____

Home or Cell Phone: _____ Work Number: _____

Relationship: _____

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.

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

_____

_____

_____

_____

SECTION 3: 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 to release 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) curb-to-curb 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:

_____

_____

How long will the applicant require ADA Paratransit Services? _____

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 St. Hamilton, Ohio 45011
Fax: - 513.785.5227
request@butlercountyrta.com

Questions about the application please contact:

513.785.5237
www.butlercountyrta.com

Bcrta
Butler County Regional Transit Authority