PACIFIC TRANSIT SYSTEM

216 N. 2nd Street Raymond, Washington 98577 (360) 875-9418 FAX (360) 942-3193

APPLICATION FOR CERTIFICATION FOR ADA DIAL-A-RIDE PARATRANSIT ELIGIBILITY WITH PACIFIC TRANSIT SYSTEM

Updated 07-13-2015

PACIFIC TRANSIT SYSTEM
216 N. 2nd Street Raymond, Washington 98577 (360) 875-9418 FAX (360) 942-3193

REQUEST FOR CERTIFICATION FOR ADA DIAL-A-RIDE PARATRANSIT ELIGIBILITY

The Americans with Disabilities Act (ADA) requires that disabled individuals be guaranteed access to transportation services. By filling out this application for Dial-A-Ride Paratransit Certification, services are provided for disabled persons unable to use fixed-route transportation.

HOW TO APPLY FOR DIAL-A-RIDE PARATRANSIT ELIGIBILTY CERTIFICATION:

1. Fill out PART A of this application. Sign on page 6. The application cannot be processed without this signature.
2. Take or send the application to your health care professional to have PART B completed.
3. Mail the completed application to:
   Pacific Transit System
   Attn: Paratransit Coordinator
   216 N. 2nd Street
   Raymond, WA 98577
4. Pacific Transit will notify you of your eligibility status. This process will take 1-3 weeks. Once we have your application in the office you will be temporarily eligible to ride the Dial-A-Ride until a determination is made.
5. If you have not heard about your eligibility status after 21 days of receiving your application, please call 875-9418 in the Raymond-South Bend area or 642-9418 in the Peninsula area.
6. If you are denied eligibility, you will have a right to appeal the eligibility decision. Please contact Pacific Transit at 875-9418 or 642-9418 for the appeals process policy.
7. If an application for ADA paratransit certification is denied the applicant may file an appeal within sixty (60) calendar days from the date of the notification letter of denial.

NOTE: The Dial-A-Ride Paratransit Certification is good for a period of 3 years only, unless temporary eligible as stated by your health professional. Another application must be filled out to continue DIAL-A-Ride Paratransit Eligibility upon expiration.

CERTIFICATION PROCESS

1. Applicant(or representative) completes PART A.
2. Health care professional completes PART B guided by the criteria explained herein.
3. Paratransit Coordinator may contact the certifying health care professional to verify the accuracy of the information.
4. Paratransit Coordinator will make the final determination as to the applicant's eligibility.
5. Applicant will receive a letter once eligibility is determined.
6. An ADA card will be sent along with the letter if determined eligible.

This application must be filled out COMPLETELY for processing to occur.

PART A: APPLICANT INFORMATION

1. NAME OF APPLICANT_____

2. PHYSICAL ADDRESS_____

   CITY_____ STATE_____ ZIP_____

3. MAILING ADDRESS_____
   (If different than physical address)

   CITY_____ STATE_____ ZIP_____

4. PHONE NUMBER (HOME)_____

   Other daytime phone number_____

5. DATE OF BIRTH_____/_____/_____

6. MALE_____ FEMALE_____

CHECK THE CATEGORY AND ALL CRITERIA THAT APPLY OR PROVIDE DESCRIPTION:

_____ CATEGORY 1

I have a physical, mental, or visual disability; or impairment, which PREVENTS me from utilizing fixed-route buses without an attendant for:

(1)_____Boarding the bus
(2)_____Riding the bus
(3)_____Disembarking the bus
(4)_____Other (describe)_____

_____

_____ CATEGORY 2

I can use buses with wheelchair lifts, but:

(1)_____Buses with wheelchair lifts are not available in my area.
(2)_____Wheelchair lifts cannot be deployed at my stop(s). List location:_____

_____ CATEGORY 3

I can use accessible buses, but have an impairment-related condition which prevents me from traveling to or from a bus boarding location. Describe the impairment of condition:_____

_____

_____

_____

MOBILITY DEVISES

Do you use any of the following aids? (check all that apply)

_____Manual Wheelchair*

_____Power Scooter*

_____Crutches

_____Service Animal: List:_____

_____Hearing-Aid

_____Communications Board

_____Prosthesis

_____Electric Wheelchair*

_____Cane

_____White Cane

_____Walker

_____Boarding Chair

_____Brace

_____Oxygen Bottle

_____Other:_____

_____

* Please note that your trip origin and destination must be accessible by ramp or lift. IF NOT ACCESSIBLE, please have someone available to assist you up and down steps. Drivers are not permitted to assist passengers up or down any steps or handle a power scooter.

REASONABLE MODIFICATION

Pacific Transit is a curb-to-curb service. Occasionally due to the disability a door-to-door service will be needed or other accommodations needed to ride the bus or van. This is known as a reasonable modification. Pacific Transit will do its best to accommodate reasonable modifications, but will consider the safety of its passengers first. Pacific Transit will deny a reasonable modification request if it will result in a service alteration, direct threat to safety, or is an undue financial and administrative burden. Keep in mind the driver will not go inside a customer's house or in a facility.

If you need a reasonable modification, state below the modification needed and why it is needed to allow the customer use of the bus or van.

_____

_____

_____

_____

_____

_____

OTHER MISCELLANOUS

Are there any other effects of your disability which we need to be aware of?

_____Obesity/weight

_____Seizures

_____Paralysis

_____Need for catheter

_____Shortness of breath

_____Dizziness

_____Other, please explain_____

_____

_____

_____

PERSONAL CARE ATTENDANTS

Do you require a Personal Care Attendant (PCA)* when you ride the bus?
Yes_____ No_____ Occasionally_____

* PCA's must be provided by the applicant or facility. Pacific Transit does not provide them.

PCA's must be available to accompany passenger(s) with or without mobility devises when the passenger cannot travel by themselves, or need help with or without their devises into or from a facility.

EMERGENCY CONTACT

In case of emergency, is there someone who should be notified?
Yes_____ No_____

If yes please complete the following:

NAME:_____

ADDRESS:_____

PHONE NUMBER:_____

RELATIONSHIP:_____

APPLICANT'S SIGNATURE AND AUTHORIZATION TO RELEASE INFORMATION

In order to allow Pacific Transit to evaluate your request for certification, it may be necessary to contact your health care professional to verify information you have provided.

I hereby certify that the information given above is correct.

I, therefore, give authorization by my health care professional to release information to Pacific Transit.

_____

Applicant's Signature

Date:_____

SIGNATURE REQUIREMENT OTHER THAN APPLICANT

If you have completed this application certification for the requesting applicant you must provide the following information:

I hereby certify that the applicant's information given above is correct.

YOUR NAME:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

DAYTIME PHONE:_____

SIGNATURE:_____

DATE:_____

PART B: PROFESSIONAL VERIFICATION

Dear Health Care Professional:

You are being asked by _____ (applicant) to provide information regarding his/her ability to use our transit services. Federal law requires that Pacific Transit provide paratransit services to persons who cannot use fixed-route transit service. The information you provide will allow us to evaluate this request and its application to specific trip requests. Thank you for your cooperation in this matter.

To qualify for DIAL-A-RIDE Paratransit service, a person must be unable to use fixed-route public transportation due to a physical or mental disability. Individuals qualify if:

1. As a result of their disability, they cannot board, ride or disembark from a Pacific Transit System fixed-route bus; or

2. They have a specific impairment-related condition which prevents* them from getting to or from a bus stop.

***PLEASE NOTE:** **This does not include persons who find it uncomfortable or difficult to get to or from a bus stop.**

Your evaluation of each person must be based solely upon the individual's ability to use a fixed-route bus. Your verification should consider only the presence of a disabling condition, not the applicant's age or economic status. Please exercise care in evaluating applicants for this DIAL-A-RIDE Paratransit Certification. False verification could result in travel limitation for persons legitimately qualified to use the DIAL-A-RIDE program.

FILLING OUT THE FOLLOWING

DIAL-A-RIDE Paratransit Service is a limited special transportation service for disabled persons who, because of a mental or physical disability, find it IMPOSSIBLE to use fixed-route transportation. Parts A, B, C, D and E must be completely filled out by the authorized health care professional who signs below. Incomplete applications will be returned.

A. Nature of Disability:

Check nature of applicant's disability (check as many items as may apply).

1._____Arthritis: Specific extremity_____
2._____Amputation: Specific extremity_____
3._____Cerebrovascular accident (stroke)
4._____Pulmonary illness:
Does applicant use portable oxygen tank? YES NO
5._____Neurological disability
6._____Cardiac ills
7._____Kidney disease: Dialysis? YES NO
8._____Sight disability:_____legally blind _____visually impaired
9._____In-coordination
10._____Developmental disability (circle one):
Moderate Severe Profound
11._____Cerebral palsy
12._____ Muscular dystrophy
13._____Autism:
describe degree of severity_____
14._____Severe muscle spasms
15._____Seizures
16._____Loss of consciousness
17._____Mental illness – Please specify what it is about this cognitive disability that makes this individual unable to use the fixed-route bus service:

_____

_____

18. _____Other disability not listed above. _____

_____

(Please specify what it is about this disability that makes this individual unable to use the fixed-route bus service):

_____

_____

_____

B. Ambulatory or Non-Ambulatory:

Applicant is:

_____Ambulatory

_____Non-ambulatory (Impaired or assisted ambulation)
Mobility Aid_____
_____Assisted by Service Dog

C. Disability Duration:
(Certification is only for a three year period, unless temporary is marked)

Mark if disability is: _____Permanent or _____Temporary.

If temporary, expected duration is _____months.

D. Personal Care Attendant Requirement:

In your opinion, must this individual bring a Personal Care Attendant to accompany the applicant to help with their mobility devise; to accompany the applicant because they cannot travel by themselves; or the applicant needs help with/without their devises into or from a facility.
_____YES _____NO

E. Other Information:

Is there any other effect of the disability of which the Paratransit Coordinator should be aware? Please provide an explanation:_____
_____
_____
_____
_____
_____
_____

HEALTH CARE PROFESSIONAL INFORMATION

My professional area is (check one):

Physician	_____	Independent Counselor	_____
Rehabilitation Counselor	_____	Social Service Professional	_____
Occupational Therapist	_____	Health Care Professional	_____

Other: (List)_____

YOUR NAME:_____

TITLE:_____

AGENCY/COMPANY NAME:_____

PROFESSIONAL LICENSE # (If applicable):_____

OFFICE ADDRESS:_____

OFFICE PHONE NUMBER:_____

I hereby certify that the above information is true and correct. The Paratransit Coordinator may verify the validity of the license and/or information given from the health professional providing the certification.

_____ _____

Signature of Health Care Professional Date

Thank you for your assistance.
Pacific Transit