1301 Kemper Street
PO Box 797
Lynchburg, VA 24505
434.455.5099
FAX: 434.847.8621

Paratransit Eligibility Application

This application is for paratransit (van) services under the
Americans with Disabilities Act (ADA).
Please call our office if you need this application in an alternative format,
such as LARGE PRINT or AUDIO TAPE.

Form I: Information from the Applicant

To be completed by applicant or representative.
Please PRINT or TYPE.

Name: _____ Date of birth: _____ /_____ /____

Address: _____

City/Town: _____ State: _____ Zip: _____

Telephone: ✆ Home (_____) _____ - _____

✆ Alternative / Work (_____) _____ - _____

1. What disability(ies) prevent(s) you from riding the regular bus service?

_____

_____

2. Do you use any of the following mobility aids:

- ❑ Manual Wheelchair
- ❑ Electric Wheelchair
- ❑ Powered Scooter
- ❑ White cane (for the visually-impaired)
- ❑ Crutches
- ❑ Walker
- ❑ Service Animal
- ❑ Walking Cane
- ❑ Portable Oxygen
- ❑ Personal Assistant/PCA
- ❑ Other _____

_____

(Note: We may not be able to accommodate you if your wheelchair or scooter is longer than 48", wider than 30", or if your total weight with your mobility device is more than 600 pounds.)

Form 1: Information from the Applicant (cont.)

3. ***Please read the following statements and check (✓) any which describe(s) you.***

You may select more than one.

- ❑ I have a disability which prevents me from boarding a regular fixed route service which does not have a lift.
- ❑ I have a disability which prevents me from boarding a fixed route service with a lift.
- ❑ I have a disability which prevents me from getting to a bus stop.
- ❑ I am afraid to ride the fixed route service.
- ❑ I have no knowledge of or experience with fixed route service, so I do not know if I am able to use it.
- ❑ There is no fixed route service bus stop near my residence.
- ❑ I can't get to a bus stop by myself, because I get disoriented or confused.
- ❑ I have a temporary disability which prevents me from taking a regular fixed route service. I will only need to use paratransit service until I recover.
- ❑ If given instructions or training on fixed route service, I think I could use it.
- ❑ My trips by fixed route service would take me too long.
- ❑ I have an episodic disability. I can use the fixed route service on those days when I am feeling well, but on "bad days", I cannot.

Please answer the following questions as they pertain to your physical mobility.

4. **If you use a riding mobility aid, how many blocks can you travel without help?** (One block = approx. 500 ft.) _____ block(s)

5. **If you use a riding mobility aid (i.e. wheelchair or scooter), can you get on and off of a wheelchair lift independently if the bus is equipped with lifts and handrails?** (Lifts are operated by the drivers.) ❑**Yes** ❑ **No**

6. **If you can walk, with or without a mobility aid, how many blocks can you walk without help?** (One block = approx. 500 ft.) _____ block(s)

7. **How many 9-inch steps can you climb without help? _____**

8. **If you are unable to climb steps, could you stand, hold onto the handrails, and ride up into a bus on a wheelchair lift if the bus was so equipped?**
   (Lifts would be operated by the drivers.) ❑**Yes** ❑ **No**

9. **How long** (with or without a mobility device) **can you wait at a bus stop? _____min.**

10. **Are you able to grasp coins, tickets, and handles?** ❑**Yes** ❑ **No**

Please answer the following questions as they pertain to your cognitive ability.

11. **Can you read informational signs?** ❑ **Yes** ❑ **No**

12. **When you travel, can you find your way around by yourself?** ❑ **Yes** ❑ **No**

13. **Can you give your address, destination and telephone number?** ❑ **Yes** ❑ **No**

14. **Can you recognize a destination or landmark?** ❑ **Yes** ❑ **No**

15. **Can you ask for, understand, and follow directions?** ❑ **Yes** ❑ **No**

16. **Can you deal with unexpected situations or changes in routine?** ❑ **Yes** ❑ **No**

Please answer the following questions as they pertain to your visual ability (sight).

17. **Can you read informational signs?** ❑ **Yes** ❑ **No**

18. **Can you recognize a destination or landmark?** ❑ **Yes** ❑ **No**

19. **When you travel, can you find your way around by yourself?** ❑ **Yes** ❑ **No**

20. **Have you received mobility training?** ❑ **Yes** ❑ **No**
    If **No**, are you on a waiting list to be mobility trained? ❑ **Yes** ❑ **No**
    If **Yes**, approx. when will the training begin _____

21. **What specific weather conditions, if any, affect your ability to ride a regular fixed route bus.** _____

Please answer the following questions as they pertain to your general ability.

22. **What terrain, road and sidewalk conditions, if any, affect your ability to ride a regular fixed route bus.** _____

23. **Will you require any assistance while traveling on our vehicle?**
    ❑ Never ❑ Always ❑ Sometimes If **Always** or **Sometimes,** explain what and when.
    _____

24. **Do you travel with a Personal Attendant/PCA?** ❑ Never ❑ Always ❑ Sometimes
    If **Sometimes**, explain when _____

25. **Please describe any other effects your disability might have on your ability to ride a regular bus, not described above.** Be specific. _____
    _____
    _____
    _____

26. **Please list the most common destinations to which or from which you travel.**
    _____
    _____
    _____
    _____
    _____

27. Release of Information and Applicant Signature

I, the applicant, understand that the purpose of this application is to determine my eligibility to use the Greater Lynchburg Transit Company (GLTC) paratransit service. I agree to release the information requested to GLTC and any eligibility review panel, and understand that the information contained herein will be treated confidentially.

I certify that the information I gave in this application is true and correct. I understand that falsification of information may result in denial of service. I understand that GLTC may contact the health care professional that I have listed below who may be asked to complete the Professional Verification (Form II) of this application in order to confirm this information or provide further information.

_____ _____

Applicant's Signature Date

- OR -

If this form is completed by someone other than the applicant, respond to the following:

Information from Person Completing Form <u>for</u> Applicant

I have read the information under **Release of Information** above, and have relayed the information to the applicant, the applicant's guardian, or have the legal authority to accept these rights and provisions on behalf of the applicant.

_____ _____

Signature of Person Completing Form for Applicant Date

Name: _____Relationship:_____
Address:_____
City/Town: _____ State: _____ Zip Code: _____
Telephone: (Home) (____) _____-_____ (Work) (____) _____-_____

28. Please provide the name of a health care professional or physician who is familiar with your disability(ies) and what effect it/they have on your mobility. It may be necessary to have this individual complete Form II (Health Care Professional Verification) in order to determine your eligibility for this paratransit service.

(Important note: The person completing Form I of this application for the applicant <u>cannot</u> also be the person completing Form II - Health Care Professional Verification)

Name: _____ Title:_____
Office Address: _____
Office Telephone: (_____) _____ - _____

Paratransit Eligibility
Application

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This is part of an application is for paratransit (van) services under the **Americans with Disabilities Act (ADA)**.

Form II: Health Care Professional Verification

To be completed by a physician or an approved health care professional only.

Please **PRINT** or **TYPE**. Use additional sheets if needed.
Complete all sections which are relevant to the applicant's disability(ies).

The Greater Lynchburg Transit Company (GLTC) provides paratransit services (curb-to-curb only transportation provided in lift-equipped vans) to individuals who cannot utilize our fixed route service (our regular large bus system). To be eligible for this paratransit service, individuals must have one or more physical or mental disabilities which prevent use of the fixed route service. *Neither age, economic status, nor distance to the nearest bus stop by themselves constitutes eligibility.*

Please answer the following questions as they pertain to _____, who has asked us to forward this application to you on his/her behalf.

As a professional familiar with the applicant's medical history, please complete this form documenting the disability or condition that prevents his or her use of the regular bus system. Please assist us by certifying only those individuals that are truly unable to use the regular bus system.

A. General Information *Complete for all applicants.*

Capacity in which you know this person? _____

_____

What disability(ies) prevent(s) this person's use of a regular fixed route service? _____

_____

_____

_____

Form II: Health Care Professional Verification (cont.)

How does the disability(ies) prevent(s) the use of a regular fixed route service? Please be complete.

_____

_____

_____

Is this temporary? ❑Yes ❑ No **If "Yes", expected duration?**_____

B. Physical Mobility *Complete for applicants whose disability physically limits his/her mobility.*

Does this person use any of the following mobility aids:

- ❑ Manual Wheelchair
- ❑ Electric Wheelchair
- ❑ Powered Scooter
- ❑ White cane (for the visually-impaired)
- ❑ Crutches
- ❑ Walker
- ❑ Service Animal
- ❑ Walking Cane
- ❑ Portable Oxygen
- ❑ Personal Assistant/PCA
- ❑ Other _____

_____

If this person uses a riding mobility aid, how many blocks can he/she travel without help? (One block = approx. 500 ft.) _____ **block(s). How does this person's disability prevent him/her from traveling more blocks?** _____

_____

If this person uses a riding mobility aid (i.e. wheelchair or scooter), **can he/she get on and off of a wheelchair lift independently if our Fixed route services were equipped with lifts and handrails?** (Lifts would be operated by the drivers.) ❑Yes ❑ No **If no, explain why not.** _____

_____

If this person can walk, with or without a mobility aid, how many blocks can he/she walk without help? (One block = approx. 500 ft.) _____ **block(s). How does this person's disability prevent him/her from walking more blocks?** _____

_____

How many 9-inch steps can this person climb without help? _____

How does this person's disability prevent him/her from climbing more?_____

_____

If this person is unable to climb steps, could he/she stand, hold onto the handrails, and ride up into a bus on a wheelchair lift if our Fixed route services were so equipped? (Lifts would be operated by

the drivers.) ❑Yes ❑ No **If "No", explain why not.** _____

_____

How many minutes can this person wait at a bus stop? _____

How does this person's disability prevent him/her from waiting longer? _____

_____

C. Cognitive Ability *Complete for applicants with a cognitive disability.*

Can this person read informational signs? ❑ Yes ❑ No **If "No", please explain.**

_____

_____

Can this person navigate independently? ❑ Yes ❑ No ❑ Sometimes
If "No" or "Sometimes", please explain. _____

_____

Can this person give his/her address, destination and telephone number upon request?
❑ Yes ❑ No ❑ Sometimes **If "Sometimes", please explain when.** _____

_____

Can this person recognize a destination or landmark? ❑ Yes ❑ No ❑ Sometimes
If "Sometimes", please explain when. _____

_____

Can this person ask for, understand, and follow directions? ❑ Yes ❑ No ❑ Sometimes
If "Sometimes", please explain when. _____

_____

Can this person deal with unexpected situations or changes in routine?
❑ Yes ❑ No ❑ Sometimes **If "No" or "Sometimes", please explain.**

_____

D. Visual Ability *Complete for applicants with a visual impairment.*

Can this person read informational signs? ❑ **Yes** ❑ **No** **If "No", please explain.**

_____

_____

Can this person navigate independently? ❑ Yes ❑ No ❑ Sometimes If "No" or "Sometimes", please explain. _____

_____

Has this person received mobility training? ❑ Yes ❑ No ❑Unknown

If "No", is this person on a waiting list to be mobility trained? ❑ Yes ❑ No ❑Unknown

If "Yes", approx. when will the training begin?_____

E. General Ability *Complete for all applicants.*

What specific weather conditions, if any, affect this person's mobility? Please explain completely.

_____

What terrain or road and sidewalk conditions, if any, affect this person's mobility? Please explain completely._____

_____

Will this person require any assistance while traveling on our vehicle?
❑ Never ❑ Always ❑ Sometimes If "Always" or "Sometimes", explain what, why and when.

_____

_____

Will this person require a Personal Attendant/PCA while traveling on our vehicle?
❑ Never ❑ Always ❑ Sometimes If "Sometimes", explain when._____

_____

Please describe any other functional limitation(s) affecting this person's mobility not described above. Be specific.

_____

_____

_____

_____

_____

In your professional opinion, does this applicant's disability prevent him/her from getting to or from, boarding, riding, or disembarking a regular Fixed route service?

❑ **Yes** ❑ **No** ❑ **Sometimes**

_____ _____

Signature of Health Care Professional **Date**

Name & Title:

_____

Office Address:

_____

City/State/Zip:

_____

Office Telephone:

_____

Return Completed form to:

GLTC
P.O. Box 797
Lynchburg, Virginia 24505
Attn: Eligibility Manager
FAX Number: (434)847-8621