



# Paratransit Eligibility Application

419 Bradley Dr. · PO Box 11286 · Lynchburg, VA 24506

Phone: 434-455-5080 · Fax: 434-616-3138

## **Form I: Information from the Applicant**

*To be completed by applicant or representative.*

This application is for paratransit (van) services under the Americans With Disabilities Act (ADA).

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

Service Animal

Electric Wheelchair

Walking Cane

Powered Scooter

Portable Oxygen

White Cane (for the visually-impaired)

Personal Assistant/PCA Crutches

Crutches

Other

Walker

\_\_\_\_\_

*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 800 pounds.*

**Form I: 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 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?** \_\_\_\_\_ Step(s)

## Form I: Information from the Applicant (cont.)

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? Yes      No  
(Lifts would be operated by the drivers.)

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?

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**Form I: Information from the Applicant (cont.)**

*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?**

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**23. Will you require any assistance while traveling on our vehicle?**

Never            Always            Sometimes

If **Always** or **Sometimes**, explain what and when.

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**24. Do you travel with a Personal Attendant/PCA?**

Never            Always            Sometimes

If **Sometimes**, explain when.

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

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

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**Form I: Information from the Applicant (cont.)**

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.

I also certify that to be transported, my mobility device may not exceed a maximum of 800 lbs. total weight when occupied and fit into a designated space.

\_\_\_\_\_  
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 for 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/State/Zip: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Alt./Work: \_\_\_\_\_

## **Form I: Information from the Applicant (cont.)**

**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 cannot also be the person completing Form II for this paratransit service.)*

**Name and Title:** \_\_\_\_\_

**Office Address:** \_\_\_\_\_

**City/State/Zip:** \_\_\_\_\_

**Office Telephone:** \_\_\_\_\_