GREATR ATTLEBORO–TAUNTON REGIONAL TRANSIT AUTHORITY (GATRA)
STATEWIDE ACCESS PASS
AND
ADA PARATRANSPORT ELIGIBILITY
APPLICATION FORM — PART A

In compliance with the Americans with Disabilities Act (ADA), GATRA provides “paratransit service” (i.e. DIAL-A-RIDE) to anyone with a disability who cannot use GATRA’s public fixed-route bus transportation and who is traveling in an area served by public buses. The area defined by ADA is 3/4 mile from GATRA’s fixed-route bus service corridor.

This application form is intended to determine when and under what circumstances the applicant can use fixed-route public buses and when Dial-A-Ride services are required.

All information will be kept confidential. Our essential personnel only will be provided with the information necessary to provide the transportation which you require. Your application will not be shared with any other person or company.

All questions must be answered. Incomplete applications will be returned to you, which will delay the application process.

GATRA reserves the right to conduct an independent evaluation of skills if the information provided is inconclusive or incomplete.

If you have questions or need assistance completing this application, please call GATRA in TAUNTON at (508) 823-8828, Ext. 273; in ATTLEBORO at (508) 226-1102, Ext. 273; or TDD at (508) 824-7439. Website: www.gatra.org

WHEN COMPLETED, PLEASE RETURN TO: GATRA
2 Oak Street
Taunton, MA 02780
Attn: Joan Gallagher

Name ________________________________ (Last) ________________________________ (First) ________________________________ (Mid. Initial) ________________________________

Phone (Home) ( ) ________________________________ Phone (Work) ( ) ________________________________

Address ________________________________ Apt. # / Bldg. # ________________________________

City or Town ________________________________ State ______ Zip Code ________________________________

Date of Birth ________________________________ Soc. Sec. # (optional) ________________________________

Emergency Contact Name ________________________________ Relationship ________________________________

Day Phone ( ) ________________________________ Evening Phone ( ) ________________________________
Are you presently riding GATRA’s fixed-route bus?  
____ Yes  ____ No

Did you previously ride the GATRA bus?  
____ Yes  ____ No

If yes, please state why you stopped riding:  


Is there something that would help you ride the fixed-route bus? (Please check all that apply)  
☐ Route and schedule information  
☐ Someone to help learn to ride the buses  
☐ A ride to and from the bus stop  
☐ None of these would help  
☐ Other: 


To the best of your knowledge, where is the closest location you can access GATRA’s fixed-route buses?  


Using a mobility aid or on your own, how far can you travel?  
____ I can travel 200 feet  
____ I can travel up to 3 blocks (¼ mile)  
____ I can travel up to 6 blocks (½ mile)  
____ I can travel up to 9 blocks (¾ mile)  
____ I cannot travel outside my residence  
____ I can get to the curb in front of my residence

Can you stand and wait up to 10 minutes for a GATRA fixed-route bus?  
____ Yes  
____ No — Please explain:


Can you get on and off of a GATRA fixed-route bus? (All of GATRA’s buses are wheelchair accessible.)  
____ Yes  
____ No — Please explain:


CURRENT TRAVEL INFORMATION

Please list three of the trips that you make most frequently on any form of public transportation:

1) FROM ADDRESS: ____________________________
   TO DESTINATION: ____________________________
   HOW MANY TIMES A WEEK DO YOU ATTEND: ____________
   HOW DO YOU GET THERE NOW? 
   Dial-A-Ride ______ Commuter Rail ______
   Fixed-Route Bus ______ Taxi ______
   Other ____________________________

2) FROM ADDRESS: ____________________________
   TO DESTINATION: ____________________________
   HOW MANY TIMES A WEEK DO YOU ATTEND: ____________
   HOW DO YOU GET THERE NOW? 
   Dial-A-Ride ______ Commuter Rail ______
   Fixed-Route Bus ______ Taxi ______
   Other ____________________________

3) FROM ADDRESS: ____________________________
   TO DESTINATION: ____________________________
   HOW MANY TIMES A WEEK DO YOU ATTEND: ____________
   HOW DO YOU GET THERE NOW? 
   Dial-A-Ride ______ Commuter Rail ______
   Fixed-Route Bus ______ Taxi ______
   Other ____________________________

TRAVEL TRAINING INFORMATION

NOTE: Travel training is one-on-one instruction that teaches an individual how to use GATRA’s fixed-route service. The person learning is accompanied at all times by the trainer until he or she is confident to travel independently.

Have you ever had any personal instruction to use GATRA’s fixed-route bus services?
   _____ Yes — GATRA Travel Training Service
   _____ Yes — I received personal instruction through an agency
   _____ Yes — I received personal instruction from a friend/relative
   _____ No — I do not need this service

Would you like to use the travel training service?  _____ Yes  _____ No
HEALTH INFORMATION

In order to allow GATRA to evaluate your request, it may be necessary to contact your Health Care or Human Service Agency Professional to confirm information that you have provided.

Please complete and sign the following authorization:

Name of Professional __________________________________________
Street Address ____________________________________________
City/Town __________________________ State _______ Zip _______
Telephone (_____) __________________________
Applicant’s Name __________________________________________
Date __________________________

Following options of licensed professionals may include: registered nurse, physician, social worker, psychologist, physical therapist, chiropractor, occupational therapist, speech pathologist, nurse practitioner, physician’s assistant, mental health counselor, respiratory therapist, vocation rehabilitation counselor, service coordinator, case manager, medical specialist or recreation therapist employed by a medical facility.

I CERTIFY THAT ALL STATEMENTS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Applicant’s Signature __________________________________________ Date ____________

If application was completed by someone other than the person requesting certification, please provide the following information:

Name __________________________________________
Street Address __________________________________________
City/Town __________________________ State _______ Zip _______
Telephone (_____) __________________________

Signed __________________________________________ Date ____________

Relationship __________________________________________
PLEASE CALL (508) 226-1102, EXT. 273, (508) 823-8828, EXT. 273, OR TDD (508) 824-7439 IF YOU NEED THIS APPLICATION AND FUTURE WRITTEN INFORMATION IN ONE OF THE FOLLOWING FORMATS:

LARGE PRINT _______________ BRAILLE _______________

AUDIO TAPE _______________ OTHER _______________

Does your disability or health condition change from time to time (or seasons) in ways which affect your ability to use the fixed-route public bus?

No ______
Yes ______ Please describe: __________________________________________________________

________________________________________________________

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

___ cane             ___ long white cane            ___ leg braces
___ crutches         ___ walker                    ___ manual wheelchair
___ powered wheelchair ___ powered scooter         ___ picture board
___ alphabet board   ___ portable oxygen          ___ service dog
___ other _____________ ___ none

Note: we may not be able to accommodate you if your wheelchair/scooter is longer than 48” or wider than 30” or if your total weight with your wheelchair is more than 600 lbs.

Do you require someone to assist you with daily life functions and/or a personal care attendant when you travel on public transportation?

___ Yes               ___ No

Are there any other conditions which limit your ability to use the fixed-route public bus?

___ No
___ Yes (Please explain) __________________________________________________________

________________________________________________________

Is your disability ____________ Permanent
Temporary ________________, expected duration is _____________________________ months
Dear Health Care Professional:

The Americans with Disabilities Act of 1990 (ADA) is a civil rights law which bans discrimination against people with disabilities. To meet their needs, public bus companies must provide a variety of services.

You have been requested by your patient/client to provide information to the Greater Attleboro-Taunton Regional Transit Authority (GATRA) regarding his/her ability to use our transit services. Federal law requires that the Greater Attleboro-Taunton Regional Transit Authority (GATRA) provide paratransit service (Dial-A-Ride) to persons who cannot use our fixed-route bus service.

Please understand that the law is quite strict in defining who is eligible for this specialized service. A person must have an actual physical or mental functional limitation which prohibits their use of accessible fixed-route public transportation.

The information that you provide describing the physical and mental capabilities of this person allows us to make an appropriate evaluation of his/her application in keeping with the requirements of the law and the best interests of the applicant. All information on this form will be kept confidential.

The processing of this person’s application cannot be completed until we receive this information from you. Thank you for your assistance.
How does this person's disability or disabilities cause functional limitations that adversely affect his/her mobility?


Is this condition ______________ Permanent
Temporary ______________ Expected duration is ______________ months
Can applicant climb stairs?  _____Yes  _____No
Read Survival Signs?  _____Yes  _____No
Hear Spoken Directions?  _____Yes  _____No
Is applicant able to take the regular fixed-route bus service? (*All of GATRA's buses are wheelchair accessible.*)  _____Yes  _____No  _____Sometimes

Explanation:


If applicant has a vision impairment, please complete the following:

<table>
<thead>
<tr>
<th>Vision Acuity with best correction:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right Eye</td>
</tr>
<tr>
<td>Left Eye</td>
</tr>
<tr>
<td>Both Eyes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Visual Fields:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right Eye</td>
</tr>
<tr>
<td>Left Eye</td>
</tr>
<tr>
<td>Both Eyes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Can the applicant read informational signs?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Able to cross busy streets and intersections?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Is applicant able to use regular fixed-route bus service despite his/her visual impairment?</th>
<th>Yes</th>
<th>No</th>
<th>Sometimes</th>
</tr>
</thead>
</table>

If no or sometimes, please explain:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

If this person has a cognitive disability, please complete the following:

<table>
<thead>
<tr>
<th>Is he/she able to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give their name, address and telephone number upon request?</td>
</tr>
<tr>
<td>Recognize a destination or landmark?</td>
</tr>
<tr>
<td>Deal with unexpected situations or unexpected changes in routine?</td>
</tr>
<tr>
<td>Ask for, understand and follow directions?</td>
</tr>
<tr>
<td>Safely and effectively travel through crowded and/or complex facilities?</td>
</tr>
</tbody>
</table>

Please describe any other functional limitation(s) affecting this person’s mobility that are not described above:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

IMPORTANT — SEE BACK PAGE!
PROFESSIONAL CERTIFICATION AND VERIFICATION

I certify that this information is correct to the best of my knowledge.

DATE: ____________________________________________

PROFESSIONAL SIGNATURE: ____________________________

LICENSED MASS I.D. NUMBER: __________________________

PHONE: ____________________________________________

PATIENT NAME: ______________________________________

Please mail completed form to:

GATRA
2 Oak Street
Taunton, MA 02780
Attn: Joan Gallagher