




**GREATER ATTLEBORO-TAUNTON REGIONAL TRANSIT AUTHORITY (GATRA)
STATEWIDE ACCESS PASS**

AND

**ADA PARATRANSIT 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 $\frac{3}{4}$ 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 _____ Phone (Home) () _____
(Last) (First) (Mid. Initial) 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 () _____



FIXED-ROUTE PUBLIC BUS

USE INFORMATION

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 ($\frac{1}{4}$ mile)
- ____ I can travel up to 6 blocks ($\frac{1}{2}$ mile)
- ____ I can travel up to 9 blocks ($\frac{3}{4}$ 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)

<input type="checkbox"/> cane	<input type="checkbox"/> long white cane	<input type="checkbox"/> leg braces
<input type="checkbox"/> crutches	<input type="checkbox"/> walker	<input type="checkbox"/> manual wheelchair
<input type="checkbox"/> powered wheelchair	<input type="checkbox"/> powered scooter	<input type="checkbox"/> picture board
<input type="checkbox"/> alphabet board	<input type="checkbox"/> portable oxygen	<input type="checkbox"/> service dog
<input type="checkbox"/> other _____	<input type="checkbox"/> 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



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**PART B:
TO BE COMPLETED BY PHYSICIAN OR AGENCY PROFESSIONAL**

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:

Vision Acuity with best correction:

Right Eye

Left Eye

Both Eyes

Visual Fields:

Right Eye

Left Eye

Both Eyes

Can the applicant read informational signs? ☐ Yes ☐ No

Able to cross busy streets and intersections? ☐ Yes ☐ No

Is applicant able to use regular fixed-route bus service despite his/her visual impairment?
☐ Yes ☐ No ☐ Sometimes

If no or sometimes, please explain:

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

Is he/she able to:

Give their name, address and telephone number upon request?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Recognize a destination or landmark?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Deal with unexpected situations or unexpected changes in routine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ask for, understand and follow directions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Safely and effectively travel through crowded and/or complex facilities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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**