ADA PARATRANSIT ELIGIBILITY FORM AND STATEWIDE ACCESS PASS APPLICATION

–PLEASE PRINT—

In compliance with the Americans with Disabilities Act (ADA), GATRA provides "paratransit service" (i.e., DIAL-A-RIDE) to anyone who cannot, due to their disability, 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 ¾ mile from GATRA's fixed- route public bus 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. Only essential GATRA personnel will be provided with the information necessary to provide the transportation you require. Your application will not be shared with any person or company.

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

GATRA has 21 days following the submission of a complete application (both Part A and Part B), to process the application. If GATRA has not decided on your eligibility after 21 days, the applicant shall be considered as eligible, and GATRA will provide service until a determination of eligibility or denial is made.

INSTRUCTIONS:

1. **The applicant must read and complete PART A of this application in its entirety. Unanswered questions may result in a denial.**

2. **After completing PART A of this application, please take PART B of the application to your licensed healthcare provider that is most familiar with your disability for certification.**

3. **Completed applications should be submitted to GATRA Administrative Offices at 10 Oak Street, Taunton, MA 02780 or faxed to 508-824-3474.**

For questions or assistance with completing your application, please call GATRA at 508-823-8828.

PART A

(PLEASE ANSWER ALL QUESTIONS)

Applicant Information:

First Name: ________________________________ Last Name: ________________________

Date of Birth: ______ /_______ /_______

Street Address: ____ Apt: _______________

City/Town: _____________________________ State: ___________ Zip Code: _____________

Home Phone #: ____________________________ Cell #: _____________________________

Email Address: ____

Preferred Communication Method: Phone _____ Email _____ Mail _____

Emergency Contact Information:

Name: _________________________________ Phone #: _____________________________

Relationship to Applicant: _____________________________

Signature:

By signing below, you certify that the information submitted in this application is true to the best of your knowledge.

Applicant Signature: ____ Date: _____________

If an applicant cannot sign their name, the legal guardian must sign on their behalf:

Legal Guardian Signature: _______________________________________ Date: ___________

Please indicate the reason(s) why you are seeking paratransit eligibility:

☐ I can use GATRA's fixed-route transportation under certain circumstances. Explain briefly:

____

____

☐ Due to my disability, I can never use GATRA fixed-route transportation. Explain briefly:

____

____

Please list two most common trips you take and how you get there:

Origin: ___________________________________ Destination: __________________________

How do you get there? ____

Origin: ___________________________________ Destination: __________________________

How do you get there? ____

Do you need the help of another person while traveling, such as a Personal Care Attendant (PCA)?

☐ Yes ☐ No ☐ Sometimes

What type of assistance do you require? ____

Do you require any of the following mobility aids:

☐ Cane ☐ Long White Cane ☐ Leg Braces ☐ Crutches ☐ Picture Board

☐ Walker ☐ Manual Wheelchair ☐ Powered Wheelchair ☐ Power Scooter

☐ Prosthesis ☐ Portable Oxygen ☐ Service Animal* ☐ Other ________________

**Note: Under the current ADA, Emotional Support Animals are not acknowledged as service animals.*

If a wheelchair or scooter is used, does it meet the following conditions for our vehicles?
Not greater than 30 inches wide 48 inches long when measured 2 inches above platform base and does not exceed 600 lbs. when occupied by applicant. These standards are set by ADA to define "common wheelchair": ☐ Yes ☐ No ☐ N/A
Note: Wheelchair lifts on paratransit vehicles are calibrated to these standards. Should your mobility aid exceed these measurements you will not be able to access the vehicles.

Check all that apply:

☐ I have a cognitive disability which prevents me from remembering and understanding all that I must do to find my way to and from the bus stop and/or ride the bus.

☐ I have a visual disability which prevents me from finding my way to and from the bus stop.

☐ I have a hearing impairment that makes it difficult to communicate or hear announcements.

☐ I have a medical condition. My condition impairs my ability to use the fixed-route bus service.

Using a mobility aid, equipment or standing on your own, what is the longest length of time that you can remain standing?

☐ 1-15 minutes ☐ 15-30 minutes ☐ 30-45 minutes ☐ 45-60 minutes

☐ Over 60 minutes ☐ I cannot stand without assistance.

How many 9-inch steps can you climb by yourself?

☐ 1-3 steps ☐ 4-6 steps ☐ 7-9 steps ☐ 10-11 steps

☐ over 12 steps ☐ I cannot climb steps without assistance.

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 (1/4 mile)

☐ I can travel up to 6 blocks (1/2 mile) ☐ I can travel up to 9 blocks (3/4 mile)

☐ I cannot travel outside my residence ☐ I can get to the curb of my residence.

Can you get on and off a GATRA fixed-route bus? (All of GATRA's buses are wheelchair accessible) ☐ Yes ☐ No ☐ Yes, with assistance.

MEDICAL INFORMATION RELEASE AUTHORIZATION

For GATRA to evaluate your request, contact a medical/clinical professional to confirm the information you provided. Please complete the following information and authorization form.

The following Licensed Health Care Professional is familiar with my disability and is authorized to provide GATRA with all information required to complete this certification.

☐ Occupational Therapist ☐ Physician ☐ Registered Nurse ☐ Nurse Practitioner

☐ Social Worker (MRC, DDS, DMH, Veteran's Agent, etc.) ☐ Neurologist

☐ Psychiatrist ☐ Physical Therapist ☐ Other ___________________

Licensed Professionals Name: ____

Medical Facility Name: ____

Street Address: ____ Apt: ________________

City/Town: ______________________________ State: ___________ Zip Code: _____________

I hereby authorize the professional listed above to release any information necessary to determine Dial-A Ride/ADA eligibility to the Greater Attleboro Taunton Regional Transit Authority (GATRA).

Applicant Name (Print): ____

Applicant Signature: _____________________________________ Date: ___________________

END OF PART A

PART B

REQUEST FOR PROFESSIONAL VERIFICATION

The patient indicated that you could provide information regarding their disability and its impact upon their ability to utilize our transit services. Federal law requires that GATRA provide paratransit services to persons who cannot use available accessible fixed-route bus services. ***(Fixed-route services are transit services where vehicles run on regular, scheduled routes with fixed stops. For example, a city bus that always travels the same route is part of the fixed-route system.)*** Please keep in mind that any condition which makes traveling to or from a boarding/disembarking location or riding on a fixed-route system more difficult or less comfortable, are not reasons for paratransit eligibility. The information you provide will let us evaluate the request and its application to specific trip requests. **Please print clearly.**

Applicant/Patient Name: ____

Capacity in which you know applicant: ____

Medical/clinical diagnosis of condition causing disability (in layman's terms)?

____

____

Is the patient's disability temporary? ☐ Yes ☐ No

If yes, expected duration until _______/_______/_______

How does this person's disability or disabilities make traveling on GATRA's fixed-route bus service difficult or impossible?

____

____

Does the applicant's disability prevent use of the fixed-route bus?

☐ Yes ☐ No ☐ Sometimes

Does the applicant require a Personal Care Attendant (PCA) when traveling?

☐ Yes ☐ No ☐ Sometimes

Would extremes in temperature affect this applicant's ability to ride the accessible fixed-route bus system? ☐ Yes ☐ No

Is the applicant currently taking medications which result in side effects which can hinder their ability to navigate the fixed-route bus system? ☐ Yes ☐ No

If yes, please explain how the side effects would hinder this applicant's ability to use the fixed-route bus service?

____

____

In your medical opinion, what other factors related to the applicant's disability affects their ability to ride the GATRA fixed-route bus system?

____

____

I certify that I have completed the questions in PART B and that the information provided is correct.

Signature of Physician/Healthcare Provider: ____

License # ____

Printed Name: ____ Date: _______________

<u>When Part B is completed, please mail or fax the completed document to GATRA. GATRA cannot process the application until the ENTIRE application (Part A and Part B) is received.</u>

The Greater Attleboro Taunton Regional Transit Authority
10 Oak Street 2nd floor
Taunton, MA 02780
Phone: 508-823-8828 Ext 263   Fax: 508-824-3474

END OF PART B