PLEASE READ BEFORE COMPLETING ADA APPLICATION:

This is an ADA (Americans with Disabilities Act) Paratransit application.

Please answer all the questions on this application including all questions related to public buses. Any blank sections or pages will be returned to you for completion. The decision on your application is based on whether your disability and how your disability **prevents** you from using the public buses or from getting to and from the closest public bus stop from your home. Please explain in detail on the application.

Attached to the application is an authorization form to obtain medical information from your doctor or specialist. If you require extra authorization forms for additional doctors, be sure to print them or request additional forms from our office.

Thank you,
Pioneer Valley Transit Authority

Please Note:

PVTA has 21 days in which to make an eligibility determination after all necessary documentation is received, which may include face to face interviews.

Application Received Date: _____
(Please leave above date blank)

ADA Paratransit Application Form

Please note: Any information given on this application will be kept confidential and shared only with professionals involved in providing the paratransit service on an as needed basis. **All questions on this application must be answered.**

For PVTA Office Use.			
Application Date:	**Form of ID#:**	**State:**	**Exp Date:**

A. Personal Information

Last Name:
First Name:

B. Current Residence

Street Address:		
Building #	Apartment #	Room #
City:	State:	Zip Code:

Is this residence:

☐ Single or Multi-Family House

☐ Apartment or Condominium Name: _____

☐ Nursing or Assisted Living Program

Name: _____

☐ Other:

C. Mailing Address (if different from residence)

Name:		
Street Address or P.O. Box:		
Building #	Apartment #	Room #
City:	State:	Zip Code:

D. Applicant's Contact Information

Home #	Cell #
TDD or Relay (for the hearing impaired) #	
Email Address: (optional)	
Language(s) spoken: ☐English ☐Spanish ☐Other (specify):	

E. Emergency Contact

Last Name:	First Name:
Relationship:	Agency (If applicable):
Primary Phone:	Email:

F. If someone assisted you in completing this form, please give the following information:

Last Name:	First Name:
Relationship:	Agency (If applicable):
Primary Phone:	Email:

G. General Information

Have you previously applied for ADA eligibility?	☐ Yes	☐ No
Is this a recertification?	☐ Yes	☐ No
Are you certified for ADA van services by another Transit Authority?	☐ Yes	☐ No

If yes:

Name of Service provider: State: Expiration Date:

/ /

H. Information About Your Disability

Part 1 Please Note that this is a two part question and must be fully completed.

Please list by name your **diagnosed** medical conditions **preventing** you from using the city bus service.

1.	4.
2.	5.
3.	6.

- If legally blind, do you have a **Certificate of Blindness**? ☐ Yes ☐ No
- If Developmental and/or Mentally Challenged condition is indicated on the application, do you have a neuropsychological evaluation showing Full Scale Intelligent Quotient (FSIQ) Or Mental Age? ☐ Yes ☐ No

Part 2 Please Note that this is a two part question and must be fully completed.

Explain how your disabilities or health related conditions **prevents** you from independently using the city bus service (If you need more space, please use the back of this page):

Do you use any of the following when you travel?

☐ Manual Wheelchair	☐ Power Wheelchair	☐ Scooter
☐ Walker	☐ Cane	☐ Crutches
☐ Respirator	☐ Service Dog	☐ Medical Equipment
☐ Oxygen if yes: ☐ Tank ☐ Compressor		☐ Communication Device
☐ Other, Explain:		

Do you need door to door help from the driver? ☐ Yes ☐ No

I. Information About Your Disability (Continued)

Is the disability or health related condition you describe:

☐ Permanent
☐ Temporary - Expected to last for how long? _____Months
☐ Unsure

Does your health condition or disability change from day to day in a way that affects your ability to use the city bus service?

☐ Yes ☐ No ☐ Sometimes

If yes, please explain:

Are there times when a personal care attendant accompanies you when you travel? ☐ Yes ☐ No ☐ Sometimes

J. Public Bus Service Experience

Do you ride the city buses?	☐ Yes	☐ No
Have you ever ridden the city buses?	☐ Yes	☐ No

If yes, how often have you ridden the city buses and to what locations?

Origin	Destination	Which city buses did you take?
1. _____	_____	_____ How often?_____
2. _____	_____	_____ How often?_____
3. _____	_____	_____ How often?_____
4. _____	_____	_____ How often?_____

If no, why don't you currently ride the city bus?

Travel Training is a free service that teaches people how to use public bus. Would you like more information about this service? ☐ Yes ☐ No

K. Functional Ability (Cognitive and Physical)

Can you find your way to a city bus stop if someone shows you once?

☐ Yes	☐ No	☐ Sometimes

How far can you walk, with or without a mobility aid?
(a block is about 500 ft)

☐ Zero Blocks	☐ 1 Block	☐ 2-4 Blocks	☐ 4+ Blocks

Can you walk up/down a gradual incline? ☐ Yes ☐ No ☐ Sometimes

A gradual incline is a gentle slope, like hills. A gradual incline seems to slowly rise – you may not even realize you're walking up (such as a hill). A gradual hill climbs, while a steep hill seems to leap up into the air.

Can you see or detect curbs, ramps, or other drop off areas?

☐ Yes	☐ No	☐ Sometimes

How long can you stand and wait at a city bus stop?

Can you get on and off a city bus?

☐ Yes	☐ No	☐ Sometimes

If no, please explain:

Can you ask for, understand and follow travel directions?

☐ Yes	☐ No	☐ Sometimes

L. Environmental Barriers

What **barriers** in the environment would **prevent** you from getting to the nearest city bus stop from your home?

☐ Lack of Curb Cuts	☐ Steep Hills	☐ No Crosswalk
☐ Sidewalks in poor condition	☐ Busy street I must cross	
☐ No Sidewalks		
☐ Other, describe:		

Explain why the conditions you indicated make it difficult to get to the city bus stops.

PLEASE NOTE:

Completed applications will be processed within 21 days of receipt of all required documents.

You will be notified by letter of your eligibility determination for ADA Paratransit service. If you have not been notified with a decision or the status of your application within 21 days, please call and we will provide you with Paratransit services until your application is processed and a final determination of eligibility is determined.

ADA Definition of a Disability in relation to the Paratransit Service:

Any person with a disability who is unable, as a result of a physical or mental impairment, and without the assistance of another individual, (except the operator of a wheelchair lift) to board, ride, or disembark from any public city bus.

Any person with a disability who has a specific impairment-related condition which **PREVENTS** them from traveling to or from a public city bus stop.

Architectural and environmental barriers such as distance, terrain or weather; do not, standing alone, form a basis for eligibility. However, a person may be eligible if the interaction of the disability and barriers **PREVENTS** the person from traveling to or from the public city bus stop. Be sure to complete section L on page 5 if this applies to you.

The eligibility requirements for the Paratransit service are defined in the Americans with Disabilities Act (ADA) as follows: Paratransit service is a safety net for people who cannot use the public city bus service. Therefore, eligible paratransit riders must have a disability that **PREVENTS** the use of the public city bus service, and not just that it makes it difficult or inconvenient.

APPLICANT'S SIGNATURE

I understand that the purpose of this application is to determine if there are times when I cannot use the public city bus service and must therefore use ADA paratransit services. I certify that to the best of my knowledge, the information in this application is true and correct. I understand that providing false or misleading information may result in a re-evaluation of my eligibility.

_____ ____ ____ ____

Your Signature or POA's Today's Date
(Please leave date blank)

*Application Date*_____

(Please leave date blank)

THIS FORM MUST BE COMPLETED BY APPLICANT, NOT DOCTOR

AUTHORIZATION TO OBTAIN PHYSICIAN OR OTHER PROFESSIONAL VERIFICATION

Please provide the following information for a physician or a licensed professional who is familiar with your medical condition and is able to provide the needed information that would help determine eligibility for ADA paratransit service. (must not be a friend or relative)

One Form Per Doctor or Specialist. If You Need Additional Authorization Forms, Please Request Them upon Completing Your ADA Application.

☐ Physician	Specialty:	☐ Rehabilitation Professional
Doctor's or Specialist's Name:		
Agency Name:		
Office Address:		
City:	State:	Zip Code:
Office Phone #	Office Fax #	
Print Applicant's Name:		D.O.B. / /
Applicant's or POA's Signature:		

Attention Doctor or Specialist

Your patient has applied for eligibility to use the PVTA ADA's Paratransit service for people with *disabilities that prevents them* from riding the regular fixed-route service; such as buses, subways and trolleys. This form authorizes your office to complete it for your patient. In order for the Eligibility/ADA Coordinator to comply with the Americans with Disabilities Act requirements, please complete and fax this form within 10 days to:

PVTA Attn: PVTA-ADA Coordinator
Fax Number: (413) 746-1659
Address: 2808 Main St, Spfld, MA 01107
Office Tel: 413-732-6248 x 2214