ADA Complementary Paratransit Service Application

PERSONAL INFORMATION

FIRST AND LAST NAME:

STREET ADDRESS:

MAILING ADDRESS:

CITY:

STATE: ZIP CODE:

DIRECTIONS TO HOME:

PHONE NUMBER (HOME):

PHONE NUMBER (WORK):

EMERGENCY CONTACT NAME:

EMERGENCY CONTACT PHONE NUMBER:

DATE OF BIRTH:

PCA ASSISTANCE NEEDS

Do you use the services of a Personal Care Assistant (PCA)?

- ◯ Yes
- ◯ No

If yes, please answer the questions in this section. If no, please move on to the next section.

PCA NAME:

PCA ADDRESS:

CITY:

STATE: ZIP CODE:

PCA PHONE NUMBER:

Please describe how your PCA assists with your transportation or trip needs.

OTHER ASSISTANCE METHODS

Do you use a service animal?

- ◯ Yes
- ◯ No

If yes, what type of animal is used and what is the animal's function?

Do you need any other assistance to ride the bus?

- ◯ Yes
- ◯ No

If yes, please explain.

BUS ACCESS

Can you climb three (3) nine (9) inch steps without assistance?

- ◯ Yes
- ◯ No

What is the maximum distance in feet you can walk without the assistance of another person?

Does hills or steps affect this distance?

- ◯ Yes
- ◯ No

DISABILITY DESCRIPTION

What is the disability that prevents you from using our fixed route service or accessing a bus stop?

How does this disability prevent you from using our fixed route service or accessing a bus stop?

Are there any other effects of your disability we should be aware of?

Is this disability condition temporary?

- ◯ Yes
- ◯ No

If yes, when will this condition end?

Do you use any of these mobility aids? Check all that apply.

- ☐ Manual wheelchair
- ☐ Power wheelchair
- ☐ Power scooter
- ☐ Cane
- ☐ Walker
- ☐ Crutches

If you use a wheelchair, what is the total weight (wheelchair + occupant) when occupied in pounds?

SIGNATURES AND CONTACT INFORMATION

I hereby certify that the information provided in this application has been answered to the best of my ability and that the information contained in this application is accurate and true.

☐ Yes

Today's Date

If this application has been completed by someone other than the person requesting certification that person must complete the following information.

NAME:

PHONE NUMBER:

RELATION TO APPLICANT:

Who may MX contact who is familiar with your disability and is certified and authorized on your behalf to provide personal information which may be required to verify the information in this application?

NAME:

PHONE NUMBER:

RELATION TO APPLICANT:

I hereby give permission for the MX to contact the above listed individual concerning my disability.

☐ Yes