ADA Paratransit Eligibility Application Form

LRTA Office for Transportation Access
100 Hale Street
Lowell, MA 01851
(978) 452-6161 EXT. 204

LRTA Use Only

I.D. #: _____

Date : _____

PART A
(This part must be completed by all applicants)

1. APPLICANT

NAME _____ SEX ☐ MALE ☐ FEMALE
First / M.I. / Last

ADDRESS _____ APT. # _____

CITY _____ STATE _____ ZIP CODE _____

EMAIL _____ DATE OF BIRTH _____
MM / DD / YYYY

HOME PHONE _____ WORK PHONE _____

2. EMERGENCY CONTACT (if applicable)

NAME _____
First / Last

HOME PHONE _____ WORK PHONE _____

RELATIONSHIP TO APPLICANT _____

Are you applying for American with Disability Act (ADA) Paratransit Eligibility?

☐ **Yes, I am applying for "ADA Paratransit Eligibility".**

COMPLETE PARTS B AND C BELOW

PART B

This part only needs to be completed if you have a disability or health condition that prevents you from sometimes or always using LRTA's fixed route bus service. Persons completing this section will be considered for "**ADA Paratransit Eligibility**." Information about disability or health condition will be kept strictly confidential.

1. What is your disability or health condition and how does it prevent you from using LRTA buses some or all of the time?

_____
_____
_____
_____
_____
_____
_____

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2. Is your disability temporary? _____

   If YES, how long is it expected to last? ____ Months ____ Years

3. Do you ever need to bring someone else with you to help you when you travel (a Personal Care Assistant PCA)?

   Yes____ No____ Occasionally ____

4. Legal Blindness (total) _____ (low vision) _____ (visually impaired but not legally blind) ____

   Dialysis patient _____ Hearing impaired _____ Deaf _____

5. Do you use a mobility aid or equipment to travel? _____

6. WHICH OF THE FOLLOWING MOBILITY AIDS OR EQUIPMENT DO YOU USE TO HELP YOU GET WHERE YOU NEED TO GO?
(Please check all that apply)

Manual Wheelchair	_____	Walker	_____	Powered Scooter	_____
Powered Wheelchair	_____	Cane	_____	Guide Cane	_____
Prosthetic Device/Brace	_____	Crutches	_____	Oxygen	_____
Service Animal (guide dog, etc.)	_____			Other	_____

Specify _____

7. CAN YOU, WITH OR WITHOUT THE MOBILITY DEVICES YOU IDENTIFIED ABOVE: (Conditions that might prevent traveling a given distance or waiting at a bus stop, such as: *lack of sidewalks, temperatures above or below _____, precipitation, during remission episodes, etc.*)

ENTER A VEHICLE WITHOUT A RAMP OR A LIFT? Yes____ No____
If sometimes, explain which conditions would prevent you_____

TRAVEL SAFELY 200 FEET WITHOUT THE ASSISTANCE OF ANOTHER PERSON?
Yes____ No____ Sometimes____ If sometimes, explain which conditions would prevent you_____

TRAVEL SAFELY 1/4 MILE WITHOUT THE ASSISTANCE OF ANOTHER PERSON?
Yes____ No____ Sometimes____ If sometimes, explain which conditions would prevent you_____

TRAVEL SAFELY 1/2 MILE WITHOUT THE ASSISTANCE OF ANOTHER PERSON?
Yes____ No____ Sometimes____ If sometimes, explain which conditions would prevent you_____

TRAVEL SAFELY 3/4 MILE WITHOUT THE ASSISTANCE OF ANOTHER PERSON?
Yes____ No____ Sometimes____ If sometimes, explain which conditions would prevent you_____

CLIMB SAFELY THREE 12-INCH STEPS WITHOUT ASSISTANCE?
Yes____ No____ Sometimes____ If sometimes, explain which conditions would prevent you_____

WAIT OUTSIDE WITHOUT FOR TEN MINUTES WITHOUT SITTING ON A BENCH?
Yes____ No____ Sometimes____ If sometimes, explain which conditions would prevent you_____

8. I CERTIFY THAT THE INFORMATION GIVEN ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE.

_____
Applicant's Signature

In our correspondence to you, which format would you prefer:

Large Print_____ Audio Tape_____

****IMPORTANT****

The information provided by your human service or health care professional **on page # 5** will only be used to help the LRTA decide if you are eligible for the ADA RoadRunner and to make sure that we understand your travel needs. **If page # 5 is incomplete we cannot determine your eligibility**. This personal information will only be shared with people who will be providing you with your transportation.

HUMAN SERVICE OR HEALTH CARE PROFESSIONAL ASSESSMENT

9. I hereby authorize my human service or health care professional to release any information necessary to determine RoadRunner eligibility to the LRTA.

Applicant's Signature:_____ Date:_____

FAXED APPLICATIONS ARE NOT ACCEPTED.

PART C

TO BE COMPLETED BY HUMAN SERVICE OR HEALTH CARE PROFESSIONAL

IMPORTANT NOTICE *TO HUMAN SERVICE OR HEALTH CARE PROFESSIONAL: The information which you provide will assist us in determining the applicant's* ***functional ability*** *to use public transportation. It is essential that you be as precise and comprehensive as possible in your evaluation. Thank you for your cooperation.*

PLEASE TYPE OR PRINT

Applicant's Name_____

Address_____

Professional relation to the applicant_____

Please provide (type or print) a narrative assessment of the applicant's functional level of mobility, describing any other effects of the disability, and noting whether you agree with the applicant's assessment of his/her functional ability to use LRTA buses:

_____

_____

_____

_____

Is the applicant able to:

Give information such as address and telephone number upon request?	**Yes____ No____**
Recognize a destination or landmark?	**Yes____ No____**
Deal with unexpected situations or unexpected change in routine?	**Yes____ No____**
Ask for, understand and follow directions?	**Yes____ No____**
Safely travel through crowded and/or complex LRTA facilities?	**Yes____ No____**
Safely travel 1/2 mile without assistance?	**Yes____ No____**
Safely travel 3/4 mile without assistance?	**Yes____ No____**

I CERTIFY THAT THE INFORMATION GIVEN ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE.

Please use the Identification stamp for the office of the HS/HC Professional below (Include name, license #, address and business phone.)

_____

Licensed/Certified HS or HC Professional

Completed form must be returned to: **LRTA Office for Transportation Access**
100 Hale Street, Lowell, MA 01851