ADA Transportations Application

All questions must be answered before your application will be considered.

PART A: To be completed by applicant or on behalf of the applicant.

Office Use ONLY: □ Approved □ Denied Date: _____ Client # _____

PLEASE PRINT: **Date:** _____

Applicant: □ Male □ Female

Last Name _____ First _____ Middle _____

Residence Address: Street _____ Apt #_____

City _____ State _____ Zip_____

Mailing Address (if different): _____

Date of Birth _____ Social Security # _____ - _____ - _____

Home # ( ) _____ Cell # ( ) _____ Work # ( ) _____

APPLICANT EMERGENCY CONTACTS (Required)

Primary:
Name _____ Relationship _____

Address _____

Home Phone ( ) _____ Cell Phone ( ) _____

Secondary Contact:
Name _____ Relationship _____

Address_____

Home # ( ) _____ Cell # ( ) _____ Work # ( ) _____

APPLICANT INFORMATION:

1. Are you a: □ Current ADA Client/Paratransit Rider □ New Applicant

2. Which of the following condition(s), if any, prevent you from using the Fixed Route system (city buses)

□ None □ Physical □ Visual □ Mental Illness

□ Brain Injury □ Deaf □ Mental Retardation □ Other _____

3. Briefly explain how your disability prevents you from using the Fixed Route Buses (city buses)

_____

_____

4. Is your disability or health condition, □ Permanent □ Temporary

Temporary; expected to last until _____

5. Please indicate the primary mobility aid you use when traveling in the community:

□ Manual wheelchair □Wheeled Walker □ Blind □ Cane

□ Foldable wheelchair □ Foldable Walker □ Segway □ Crutches

□ Power wheelchair □ Service Animal □ Hearing Device □ Leg Braces

□ Scooter □ Oxygen Tank □ Prosthesis □ Other _____

Note: WTS may not be able to accommodate you if your wheelchair or scooter is longer than 48" or wider than 30" or if your total weight with your wheelchair is more than 800 pounds. (ADA s 37.165)

6. Can you climb ten steps with a handrail, without assistance from another person?

□ YES □ NO

If no, why not?

_____

_____

7. If applicant has a disability affecting mobility, please indicate what distance you are able to travel without the assistance of another person.

_____ less than 200 ft.	_____ 5 to 6 blocks
_____ 1 to 2 blocks	_____ 7 to 8 blocks
_____ 3 to 4 blocks	_____ 9 or more blocks

8. Do you require a Personal Care Attendant (PCA) to help you travel?

□ YES □ NO □ Sometimes

9. Have you ever used the Fixed Route service (city buses)?

□ YES □ NO

10. If so, why are you no longer able to use the Fixed Route city buses?

_____

_____

_____

11. If you have a cognitive disability, are you able to: (check all that apply)

□ Give name, address and telephone numbers upon request.
□ Recognize a destination or landmark?
□ Deal with unexpected situation or unexpected changes in routine?
□ Ask for, understand, and follow directions?
□ Safely and effectively travel through crowded and/or complex facilities?

Explain:

_____

_____

_____

12. Describe your neighborhood: (check all that apply)

□ side walks in front of your residence
□ wheel chair ramps at your residence
□ paved road in front of your residence
□ unpaved road in front of your residence

ACKNOWLEDGEMENT

I agree to pay the exact fare for each trip. I agree to notify Waco Transit of any changes in my mobility status, which may affect my eligibility to use the service. I also understand that failure to adhere to the policies and procedures will be grounds for suspending or revoking my application and right to use the Waco Transit service. I understand and agree to hold Waco Transit System harmless against all claims or liability for damages to any person, property, or personal injury occurring as a result of my failure to equip or maintain the safety measures of the adaptive equipment or service animal that I require for mobility. I understand that providing false and misleading information could result in my eligibility status being terminated. I have read and fully understand the conditions for service outlined above and agree to abide by them.

To the Applicant: I give permission for WTS staff to contact the professional who has filled out this application or given supplemental verification of my condition. I certify that the information provided in this application is true and correct based upon the information given to me by the applicant

Sign below to allow the release of information from the professional who will be filling out this form
I hereby request that information pertaining to limitations that prevent me from using Fixed Route buses be released to W.T.S for further determination of my ADA paratransit eligibility.

Print Name: _____

Applicant's signature: _____ Date: _____

If someone other than the person requesting certification has completed this application form, please complete the following:

Print Name _____ Day Phone ( ) _____

Address _____ City _____ State _____ Zip_____

Relationship to Applicant _____

Agency Name _____

Signature _____ Date_____

Please return your completed application to the Administration Building at the:
Waco Transit System 301 S 8th Street Suite 100 or mail to:
Waco Transit System
301 S 8th Street Suite 100 Waco Texas 76701

PART B: TO BE COMPLETED BY A MEDICAL PROFESSIONAL ONLY

Health Care Professional,

The applicant is asking you to review the information on this application and to complete and sign part B of this form certifying that they have a disability that prevents them from using Fixed Route buses (city buses). This information will be use to help determine weather or not the applicant needs to use Paratransit (door to door) service or is able to use Fixed Route service for their travel needs. To be completed by a medical professional who is knowledgeable about the applicant's functional ability.

We need to know the limitation of their disability that limits their ability to ride the Fixed Route Bus. The following is necessary for us too process this applicant's request:

- Thorough details of the applicants functional limitations, and how they inhibit that person's ability to board and use a Fixed Route bus.

- Thorough details of the applicant's cognitive limitations, and how they inhibit that person's ability to navigate using a Fixed Route bus.

- Thorough details of the applicant's physical limitation, and how they inhibit that person's ability to reach a bus stop or the destination from a bus stop.

Under the Americans with Disability Act (ADA), if a person has the functional capability to use W.T.S. Fixed Route city buses that person is not eligible for paratransit service (door to door). Disability alone and distance to and from a bus stop, by itself, does not qualify a person for W.T.S paratransit service.

Thank you for your assistance. If you have any questions while completing this form, please feel free to contact us at 254-750-1620 or 254-750-1621.

Name of Patient/Applicant _____ Date of Birth_____

TO BE COMPLETED BY A MEDICAL PROFESSIONAL ONLY

To the Medical Professional completing this form: Medical Professional ONLY

This form must be filled out by a professional who is knowledgeable about the applicant's disability and their limitations. Please check the appropriate box regarding the person completing this form.

□ Vocational Rehabilitation Counselor
□ Licensed Social Worker
□ Respiratory Therapist
□ Psychologist
□ Psychiatrist
□ Audiologist
□ O & M Instructor
□ Physician
□ Physical Therapist
□ Mental Health Counselor
□ Podiatrist
□ Optometrist

Other_____

1. Indicate nature of applicant's disability (check all that apply) Medical Professional ONLY

□ Impaired or assisted ambulation: Specify mobility aid: _____
□ Cerebrovascular Accident
□ Autism
□ Deaf / Hard of Hearing
□ Cardiac
□ Kidney Disease
□ Dialysis
□ Legally Blind
□ Severely Visually Impaired
□ Alzheimer's
□ Dementia
□ Cerebral Palsy
□ Pulmonary: Does applicant travel with Portable Oxygen Tank? □ Yes □ No
□ Mental Retardation (indicate one: □ Moderate □ Severe □ Profound)
□ Mental Illness (Specify type) _____
□ Seizures: Specify nature of: _____
□ Arthritis: Specify extremity: _____
□ Neurological Handicap (Specify) _____
□ Other_____

2. In your opinion can the applicant use a: Medical Professional ONLY

□ Fixed Route Service (regular city bus) OR □ Parartransit (door to door) bus service

If door to door service is needed, please describe the physical and/ or cognitive condition and how it functionally prevents the applicant from using regular city buses:

_____
_____

3. What is the expected duration of the applicant disability? Medical Professional ONLY

□ Permanent □ Temporary Expected duration_____

If the applicant has a cognitive disability, is the applicant able to:

Give addresses and telephone numbers upon request?
□ Yes □ No

Recognize a destination or landmark?
□ Yes □ No

Deal with unexpected situations or unexpected change in routine?
□ Yes □ No

Ask for direction and follow directions
□ Yes □ No

4. Does the applicant require a personal care attendant? Medical Professional ONLY
□ Never □ Always □ Sometimes

5. If vision impaired, what is **Best Corrected Acuity** (Snell)?
Right eye_____ Left eye_____

Visual Field Restriction: Right_____ Left_____

Visual impairment diagnosis: _____

_____

6. Please indicate the primary mobility aid you use when traveling in the community:

□ Cane □ Crutches □ Blind □ Walker

□ Walker □ Scooter □ Segway □ Prosthesis

□ Power wheelchair □ Service Animal □ Hearing Device □ Oxygen Tank

□ Manual wheelchair □ Leg Braces □ Foldable wheelchair Other _____

7. How far can applicant walk or wheel themselves without assistance from another person?

_____

PROFESSIONAL CERTIFICATION Medical Professional ONLY

Qualified professional must complete this section. Please print or type.

Person Completing Form: _____
Professional Title: _____
Agency/Affiliation: _____
Business Address: _____

City: _____ State _____ Phone #_____

OFFICE USE ONLY

Date Application Received: _____

Date Approved: _____

Date Denied: _____

Date Applicant Notified: _____

Staff Signature: _____