



***DIAL-A-RIDE APPLICATION
AND
PARATRANSIT CERTIFICATION FORM***

PLEASE READ THIS SECTION BEFORE YOU BEGIN

About this application – The Americans with Disabilities Act (ADA) ensures that people with disabilities receive public transportation comparable to the public transportation available to people without disabilities. CCAT provides door to door service also known as dial-a-ride – to people who are unable to use the fixed route transit service because of a disability. This application form is intended to determine when and under what circumstances the applicant can use buses and when dial-a-ride service is required. This service is available for any trip purpose without restrictions.

Who should apply? Anyone with a disability which prevents them from traveling to or from a regular bus stop, or from independently boarding, riding and getting off a regular fixed route transit vehicle. If you need assistance from another person, other than the driver, when riding a fixed route your assistant can ride for free.

Instructions – The applicant (or someone assisting them) must complete PAGES 1-5. A Licensed Professional must complete and sign the PROFESSIONAL VERIFICATION section (page 6). In addition, an in-person interview with CCAT staff may be scheduled to determine eligibility. Information regarding the CCAT PARATRANSIT program and its services will be explained to applicants at that time. Applicants will then be informed of CCAT's determination by mail. If you have any questions about completing this application, call CCAT at (541)267-7111. Hearing impaired can call 7-1-1 for assistance.

INCOMPLETE APPLICATIONS WILL BE RETURNED UNPROCESSED. When completed, return the entire form to:

**Mail To: Coos County Area Transit
2810 Ocean Blvd SE
Coos Bay, OR 97420**

Fax: 541-267-0393

Coos County Area Transit – Application Form

Last Name _____ First _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Date of Birth _____

Name of emergency contact person _____

That person's phone number _____

Which of the following mobility aids (supplied by you) do you use when traveling?

A. Motorized wheelchair Scooter Manual wheelchair

B. Cane Walker Crutches

C. Oxygen

D. Service Animal Type of Animal _____

E. Personal Care Attendant (PCA)-someone designated by you to assist you with one or more daily life functions and as necessary with your mobility. For what reason is a PCA needed?

F. None of the above

Can you use the bus stop nearest your home? Yes No

If no, why not? (Example: no shelter, no curb cut, no bench, etc.)

How far, in city blocks, is the nearest bus stop to your home? _____

Please check a box for each question:

		Always	Never	Sometimes
a.	I can ride CCAT buses by myself (without assistance from someone other than the driver)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	I need a lift to board the bus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	I can walk (or travel with my mobility device) to the bus stop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	I could probably ride the regular bus with some training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any box checked "Sometimes"

Have you ever ridden a regular CCAT bus? Yes No

Have you ridden a regular CCAT bus in the past 6 months? Yes No

If yes, how many times a month do you ride? _____

What bus route(s) do you usually ride? _____

What are the major factors in your decision to apply for the CCAT PARATRANSIT service?

DISABILITY INFORMATION

1. Are you able to complete the following tasks without assistance from another person?
(Check a box for each question.)

		Always	Never	Sometimes
a.	Get to/from the bus stop?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	Walk (or travel using mobility device) five blocks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	Get on/off a regular bus without using a lift?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	Get on/off a regular bus using a lift?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e.	Climb three 10 inch steps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f.	Wait at a bus stop for 30 minutes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g.	Maintain your balance entering, exiting and riding a regular bus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h.	Understand and follow verbal directions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i.	Recognize correct stops and landmarks to complete a trip?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j.	Hear stops announced by the driver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k.	Read and understand informational signs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l.	Plan a trip using public transportation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m.	Communicate information about yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any boxes checked "Sometimes"

CERTIFICATION

1. What is your disability?

- Visual Impairment _____
- Mobility Impairment _____
- Cognitive/Psychological _____
- Cardiovascular/Respiratory _____
- Other _____

2. If you have visual impairment, please check each box that describes your disability

- | | |
|--|---|
| <input type="checkbox"/> Totally blind | <input type="checkbox"/> light perception |
| <input type="checkbox"/> severely blurred/distorted vision | <input type="checkbox"/> night blindness |
| <input type="checkbox"/> mildly blurred/distorted vision | <input type="checkbox"/> severe glare sensitivity |
| <input type="checkbox"/> Central visual field loss | <input type="checkbox"/> tunnel vision |
| <input type="checkbox"/> Half field loss | <input type="checkbox"/> loss of depth perception |
| <input type="checkbox"/> Other _____ | |

3. How does your disability prevent you from using a regular lift-equipped bus?

4. Is your disability (check one) permanent temporary until _____
 Episodic (please describe) _____

5. Do you have other health problems that CCAT needs to be aware of? (Examples: shortness of breath, seizures, dizziness, muscle weakness, fatigue, lack of coordination, etc.)

6. In city blocks:

- a. How far can you walk? _____
- b. If you use a wheelchair or scooter, how far can you travel in blocks?

7. Is your ability to walk (or travel using a mobility device) affected by weather?

- No Yes explain: _____

8. Is your ability to walk (or travel using a mobility device) affected by terrain?

- No Yes explain: _____

CERTIFICATION

A. APPLICANT

I certify that the information I gave in this application is true and correct. I understand that falsification of information may result in denial of service. I understand all information will be kept confidential, and only the information required to provide the services that I request will be disclosed to those who perform those services.

Applicant Signature: _____

Date: _____

B. PERSON COMPLETING FORM IF OTHER THAN APPLICANT

(Please check one):

I certify that the information provided in this application is true and correct, based on information given me by the applicant.

I certify that the information provided in this application is true and correct, based on my own knowledge of the applicant's health, disability or condition.

Exceptions or additions _____

Signature _____ Date _____

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

Relationship to Applicant _____

PROFESSIONAL VERIFICATION
(To be completed by a licensed professional)

The Americans with Disabilities Act of 1990 (ADA) is a civil rights law which bans discrimination against people with disabilities. Based on functional ability, the applicant may be found eligible for this service. The information you provide will enable us to make an appropriate determination for this applicant. All information will be kept confidential. Thank you for your assistance.

The page MUST be completed by one of the following currently licensed professionals ONLY.

- | | |
|--|--|
| <input type="checkbox"/> Vocational Rehabilitation Counselor | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> Special Education Teacher | <input type="checkbox"/> Physician's Assistant |
| <input type="checkbox"/> Physician | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Respiratory Therapist | <input type="checkbox"/> Occupational Therapist |
| <input type="checkbox"/> Registered Nurse | <input type="checkbox"/> Nurse Practitioner |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Travel Trainer | <input type="checkbox"/> Mobility Instructor for Visually Impaired |

Patient Name _____

Diagnosis (es) _____

Functional Limitations _____

Is this condition temporary? Yes, for _____ weeks/months No

I certify that the information contained in this application is true and correct to the best of my knowledge and ability.

Signature _____ Date _____

Print Name _____ Daytime Phone _____

Clinic/Agency _____

Address _____