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 in 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. The applicant needs to sign application regardless if filled out by another individual. 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
93781 Newport Lane
Coos Bay, OR 97420

Fax: (541) 267-0194

Coos County Area Transit
93781 Newport Lane
Coos Bay, OR 97420
Office: (541)267-7111 Fax: (541) 267-0194

ADA Paratransit Application Form

Last Name _____First _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Date of Birth _____ Male ☐ Female ☐ Other ☐

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

Dimensions of wheelchair or scooter _____

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)	☐	☐	☐
b.	I need a lift to board the bus	☐	☐	☐
c.	I can walk (or travel with my mobility device) to the bus stop	☐	☐	☐
d.	I could probably ride the regular bus with some training	☐	☐	☐

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?	☐	☐	☐
b.	Walk (or travel using mobility device) five blocks?	☐	☐	☐
c.	Get on/off a regular bus without using a lift?	☐	☐	☐
d.	Get on/off a regular bus using a lift?	☐	☐	☐
e.	Climb three 10 inch steps?	☐	☐	☐
f.	Wait at a bus stop for 30 minutes?	☐	☐	☐
g.	Maintain your balance entering, exiting and riding a regular bus?	☐	☐	☐
h.	Understand and follow verbal directions?	☐	☐	☐
i.	Recognize correct stops and landmarks to complete a trip?	☐	☐	☐
j.	Hear stops announced by the driver?	☐	☐	☐
k.	Read and understand informational signs?	☐	☐	☐
l.	Plan a trip using public transportation?	☐	☐	☐
m.	Communicate information about yourself?	☐	☐	☐

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

   □ Totally blind
   □ severely blurred/distorted vision
   □ mildly blurred/distorted vision
   □ Central visual field loss
   □ Half field loss
   □ light perception
   □ night blindness
   □ severe glare sensitivity
   □ tunnel vision
   □ loss of depth perception
   □ 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 of 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.

This page MUST be completed by one of the following licensed professionals ONLY.
Applicant will be denied unless completely filled out in full.

___ Vocational Rehabilitation Counselor
___ Special Education Teacher
___ Physician
___ Respiratory Therapist
___ Registered Nurse
___ Chiropractor
___ Travel Trainer
___ Psychiatrist
___ Physician's Assistant
___ Physical Therapist
___ Occupational Therapist
___ Nurse Practitioner
___ Social Worker
___ Mobility Instructor for Visually Impaired

Patient Name _____

Please describe conditions precluding the applicant from using mass transit services:

_____

_____

_____

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 _____