

**APPLICATION INSTRUCTIONS**

Americans with Disabilities Act (ADA) | Demand Response Eligibility

All applicants must submit a complete application which includes **both forms**

## The Certification Questionnaire Form

1. **The Professional Verification Form**

**STEP1** COMPLETE THE CERTIFICATION QUESTIONNAIRE

The **Certification Questionnaire** should be filled out by the applicant or the applicant’s advocate. The form must be filled out in its entirety. It should be signed by the applicant or the applicant’s guardian and anyone who assisted the applicant in completing the application.

The Professional Verification Form must be completed by one of the following professionals who are familiar with the applicant’s condition:

**STEP2** COMPLETE THE PROFESSIONAL VERIFICATION FORM

* + Physicians or Psychiatrists
	+ Occupational Therapists
	+ Psychologists
	+ Physical Therapists
	+ Licensed Clinical Social Worker (LCSW,LMSW)
	+ Speech/Language Pathologists
	+ Certified Orientation and Mobility Specialists
	+ Registered Nurses (RN)
	+ Doctor of Chiropractic (DC)

## To complete the Professional Verification Form

1. Complete and sign the Authorization to Release Information.
2. Send the **Professional Verification** Form to your designated professional.
3. Wait for your professional to return the **Professional Verification** Form to you. Check back with your professional if you have not received the form back in a timely manner.

*See additional info on back*

**STEP3** SUBMIT BOTH FORMS TOGETHER

Submit both the **Certification Questionnaire** and the **Professional Verification** Form in the **same envelope** to:

 **Mail or Return in Person to:**

 **CCATD**

 **2810 Ocean Blvd SE**

 **Coos Bay, OR 97420**

 **Fax: 541-982-5381 or Email: skellyirvin@coostransit.org**

In order to make a determination within 21 calendar days, CCATD’s Accessible Transportation Department must have a complete application. There are several things which may cause an application to be incomplete. By double checking these items PRIOR to submitting your application, you may avoid delays in processing.

COMMON ISSUES

1. **One of the forms is missing.** Your application must contain both the Certification Questionnaire and the Professional Verification. Please ensure both are submitted in the same envelope.
2. **One of the forms is not signed.** Both the Certification Questionnaire and the Professional Verification forms must be signed. If either the applicant or the professional forgets to sign the form, it is considered incomplete.
3. **The professional credentials are missing.** Professionals must include their titles and credentials when signing the Professional Verification.

**Questions? Please call 541.267.7111**

Important to note: You can schedule a ride after your application is received

and you are waiting for your determination notification.

**CERTIFICATION QUESTIONNAIRE**

Americans with Disabilities Act (ADA) | Demand Response Eligibility

1. See application Instructions
2. If you have additional questions call the CCATD Accessible Transportation Customer Service at (541) 267-7111 voice, 7-1-1 TTY.
3. This form is incomplete if it is NOT ACCOMPANIED BY COMPLETED PROFESSIONAL VERIFICATION.

**Please print or type**

**PART1** APPLICANT DATA

Name:

First Middle Initial Last

Street Address: Apt.#:

City: Zip Code: Day Telephone: ( ) Evening Telephone: ( ) Email Address:

Birth Date: / /

I am a Veteran of the US Armed Forces. Yes No

## Mailing Address (if different from above)

Street Address: Apt.#: City: Zip Code:

*By providing emergency/alternate contact numbers, you authorize CCATD or its representatives to contact the individuals listed regarding your Demand Response service.*

## Emergency Contact Person

Name:

First Last Relationship

Day Telephone: ( ) Evening Telephone: ( )

1. **Which of the following assistive devices, if any, do you use:** *(please check all that apply)*

|  |  |  |  |
| --- | --- | --- | --- |
| Cane | Manual Wheelchair | Boarding Chair | Prosthesis |
| White Cane | Powered Wheelchair | Service Animal | Communication Aid |
| Walker | Powered Scooter | Portable Oxygen | Crutches |

Cart Other:

## A close up of a map  Description generated with very high confidenceIf you use a wheelchair or scooter:

Is it more than 30 inches wide? \_\_\_\_\_YES \_\_\_\_\_\_NO

 Is it more than 48 inches long? \_\_\_\_\_ YES \_\_\_\_\_\_NO

1. **Do you need to travel with a Personal Care Attendant (PCA)?** *A PCA is someone designated or employed specifically to assist you meet your personal needs. CCATD cannot provide you a PCA and*  *our drivers cannot serve as your PCA. (Select one)*

**No** – You may still have someone travel with you whenever you wish

**Sometimes** – you travel with a PCA at your own discretion

**Yes** – You cannot travel alone and always need to travel with a PCA.

**PART2** QUESTIONS ABOUT USING FIXED-ROUTE PUBLIC TRANSIT

Complete Part 2 even if you are unable to use fixed-route bus service. This information will assist us in determining how your disability/health condition affects your ability to use fixed-route bus service.

1. **Do you now independently use fixed-route bus service?**\_\_\_\_Yes No \_\_\_Sometimes

## Have you ever had training to use the fixed-route bus service? Yes \_No

## Would you like to schedule time with our travel trainer? Yes \_No

##

The information provided on this form is private data and is used to determine ADA paratransit eligibility. The ability to determine your eligibility is based on receiving all the information requested on this form. No information related to CCATD’s Accessible Transportation Services can be released to anyone else without the applicant’s signature. I certify that all information on this application form is accurate.

**PART3** APPLICANT SIGNATURE

**Applicant’s Signature:** Date: / \_/

\*If the applicant is not his/her own guardian, the following information about the guardian is required:

Guardian’s Name: *(please print)*

First Last Relationship

Contact Phone: ( )

**Guardian’s Signature:** \_ \_ \_ Date: / /

\*If someone other than the applicant or the applicant’s guardian is preparing this form, please provide the following information about the preparer:

Name:*(please print)*

First Last Relationship

Contact Phone: ( )

**ELIGIBILITY APPLICATION PROFESSIONAL VERIFICATION**

Americans with Disabilities Act (ADA) | Demand Response Eligibility

1. **Complete and sign** the “Authorization to Release Information”.
2. **Send** to your designated medical professional.
3. **Wait** for your medical professional to return this form to you.

Check back with your medical professional if you don’t receive your information.

1. **This form is incomplete if it is NOT ACCOMPANIED BY COMPLETED CERTIFICATION QUESTIONNAIRE.**

**PLEASE PRINT OR TYPE**

**PART3** APPLICANT SIGNATURE

#  (WHEN COMPLETE SEND TO THE PROFESSIONAL YOU NAMED)

Applicant’s Name:

First Middle Initial Last

Birth Date: \_/\_ /

Applicant’s Address: Apt.#:

City: State: Zip Code:

Applicant’s Telephone Number ( )

I authorize the following professional to release to CCATD specific information as requested. It is my understanding that the information released will be used solely to determine my ADA demand response eligibility. I understand that I may revoke this authorization at any time. Unless revoked, this form will allow that professional listed below to release information described for six months after the date appearing below.

Name of Professional: Title:

Applicant’s Signature: \_Date: / \_ /

Guardian’s signature required if the applicant is not his/her own guardian,

Guardian’s Signature: Date:\_ / \_ /

**SECTION B** PROFESSIONAL VERIFICATION FORM

## Dear Health Care Professional:

You are being asked to provide information regarding this individual’s disability. The Federal Law is very specific about ADA para-transit eligibility. The law restricts eligibility to individuals who:

* 1. As a result of their disability, cannot board, ride, or disembark from a regular fixed route bus or;
	2. Have a specific impairment-related condition which prevents them from getting to or from a bus stop.

**PLEASE NOTE:** This **does not** include persons who find it **difficult or uncomfortable** to get to and from bus stops. In providing information you should consider only the presence of a disability or health condition and not the applicant’s age or economic status. CCATD Accessible Transportation staff makes the final determination on eligibility status.

#  THIS SECTION MUST BE FILLED OUT FOR ALL APPLICANTS

GENERAL INFORMATION

* Describe the diagnosed disability you are currently treating this individual for:
* Is their disability temporary or permanent ?
* Is the individual’s judgment impaired? Yes No
* Is the individual’s vision impaired? Yes No
* Is behavioral inhibition impaired? Yes No
* Can the individual walk? Yes No
* Does the individual use a mobility aid? Yes No Please list:
* Can the individual be left alone? Yes No \*Sometimes

\*Please explain:

PLEASE RETURN FORM TO APPLICANT **PLEASE PRINT so that we may contact you if needed**

Additional Comments:

Name of Professional: \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_

City:

State:

Zip Code:

Telephone Number: ( ) \_ \_ Fax: ( )

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Doctor/Heathcare Professional Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**