Virginia Regional Transit

ADA Transportation Application

In compliance with the American Disabilities Act (ADA), Virginia Regional Transit provides a shared ride, advanced reservation, origin to destination service for disabled individuals who are unable to use regular fixed route public transportation services because of their disabilities.

To be eligible for service, the functional limitations of an individual's disability must prevent use of regular fixed route buses. **Paratransit service is not available to persons who find it uncomfortable or difficult to get to and from bus stops.**

Please be aware that Virginia Regional Transit provides two types of public transportation:

1. **Fixed Route** buses provide service at designated bus stops along specific routes according to set schedules. Many fixed route buses have features to make riding easier for people with disabilities including wheelchair lifts and handrails for entering and exiting the bus.

2. **Paratransit Service** is a shared ride, advanced reservation, origin to destination public transportation service for people whose disability prevents them from riding fixed route buses. You must receive certified approval to use this service and must call in advance to make a reservation to travel.

Applications MUST BE CERTIFIED by a licensed or certified health care professional every 2 years and within 30 days of expiration

Your ability to ride fixed route buses will be evaluated through use of this application, and in some circumstances, an in-person interview. Each application will be evaluated on a case-by-case basis, taking into consideration all of the information provided.

Applications are processed in the order in which they are received. A determination will be made within 15 days of receipt of the application and you will be notified of this decision in writing.

It is very important that the application be filled out completely. Incomplete and illegible applications will not be processed and will be returned. Applications must have original signatures, as faxed or photocopied signatures are not permitted.

If you have any questions concerning this application or paratransit services, please contact the ADA operations supervisor at (540)338-1610, ext 1302 or toll free at 1-877-777-2708.

Please submit completed ADA applications to your regional office:

Virginia Regional Transit
Loudoun Region
PO Box 4665
Purcellville, VA 20134

Virginia Regional Transit
Mountain Region
51 Ivy Ridge Lane
Fishersville, VA 22939

Virginia Regional Transit
Central Region
1099 Brandy Knoll Court
Culpeper, VA 22701

For Office Use Only

ID# _____ Expiration Date: _____

(Circle) Approved / Denied By: _____

Date: _____

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PART I: GENERAL INFORMATION

Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Apt or Bldg#)

_____
(City) (State) (Zip Code) (County)

Mailing Address (If Different): _____
(Apt or Bldg#)

_____
(City) (State) (Zip Code) (County)

Home Phone: _____ Work Phone: _____

Social Security Number: _____ Date of Birth: _____
(Last 4 Digits Only)

Emergency Contact

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Are you eligible for : ❑ Medicaid or ❑ Medicare

Are you a customer of another Paratransit system? _____
(Name of System)

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PART II: USING FIXED ROUTE SERVICES

1. Please check all applicable boxes of mobility aids or equipment you currently use.

- ❑ Walking Cane
- ❑ Walker
- ❑ Powered Scooter/Cart
- ❑ Orthopedic Cane (3-4 Prong)
- ❑ Leg Braces
- ❑ Respirator/Oxygen Tank
- ❑ Long White Cane (Vision Impaired)
- ❑ Manual Wheelchair
- ❑ Other
- ❑ Service/Guide Animal
- ❑ Powered Wheelchair
- ❑ I do not require any assistive devices

2. Have you ever used our fixed route services?

- ❑ Yes, I typically ride _____ times a week.
- ❑ Yes, I have previously but stopped because: _____
- ❑ No, I have never used Virginia Regional Transit's fixed route services.
- ❑ No, but I would be interested in learning how to use your regular service.

3. How far from your home is the nearest bus stop?

- ❑ Less than 1 block
- ❑ 1 - 2 blocks
- ❑ 3 - 4 blocks
- ❑ 5 or more blocks
- ❑ I do not know

4. On your own, or using your assistive device, how far can you travel on level ground?

- ❑ I can get to the curb in front of my house/apartment.
- ❑ I can travel up to 3 blocks (1/4 mile).
- ❑ I can travel up to 6 blocks (1/2 mile).
- ❑ I can travel up to 9 blocks (3/4 mile).

5. WITHOUT the help of someone else can you:

Ask for, understand, and follow written or spoken instructions?	❑ Yes	❑ No	❑ Sometimes
Cross the street, either on your own or with an assistive device?	❑ Yes	❑ No	❑ Sometimes
Stand for 30 minutes if there is no place to sit?	❑ Yes	❑ No	❑ Sometimes
Step on and off a sidewalk from the curb?	❑ Yes	❑ No	❑ Sometimes
Find your own way to the bus stop if shown the way?	❑ Yes	❑ No	❑ Sometimes
Walk up and down three steps if there is a handrail?	❑ Yes	❑ No	❑ Sometimes
Stand on a moving bus if holding on to a handrail?	❑ Yes	❑ No	❑ Sometimes

6. Please explain how your disability prevents you from using Virginia Regional Transit's fixed route services.

_____

_____

_____

_____

PART III: APPLICANT CERTIFICATION

I certify to the best of my knowledge and ability, the information in this application is true and correct. I hereby authorize permission to the licensed health care professional to release any relevant information for the purpose of evaluating my eligibility to use paratransit services.

I understand that approval of this certification will be for a term of 2 years and I it is my responsibility to initiate recertification within 30 days of expiration.

Applicant Signature: _____ Date: _____

If this application was completed for you by another person, please provide the following information.

Name: _____ Contact Number: _____

Address: _____

Agency or Clinic (if applicable): _____

Relationship to Applicant: _____

Signature: _____ Date: _____

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PART IV: PROFESSIONAL CERTIFICATION

This portion MUST BE COMPLETED by a licensed or certified health care professional

The Americans with Disabilities Act of 1990 (ADA) requires the provisional of paratransit service to **anyone who is prevented from using the regular transit system, by reason of physical or mental limitation, and who is traveling in an area served by the system.**

The applicant who has asked you to review and sign this form is seeking eligibility for Paratransit Specialized Transportation service. This application is intended to determine whether applicant can use regular transit services or whether he/she requires origin to destination service.

Resources for this program are limited so please exercise care in evaluating this applicant. Your evaluation must be based solely upon the applicant's ability to use regular transit services. False verification could result in travel limitations for persons legitimately qualified to use this program.

Please carefully review the information provided by the applicant and answer the questions below.

Name of Applicant: _____

1. Please mark all disabilities which prevent the applicant from using fixed route bus services. Conditions that make it difficult or uncomfortable should not be checked.

Neuromuscular

- ❑ Arthritis
- ❑ Amputation
- ❑ Cerebral Palsy
- ❑ Multiple Sclerosis
- ❑ Muscular Dystrophy
- ❑ Paraplegia
- ❑ Parkinson's Disease
- ❑ Polio
- ❑ Quadriplegia
- ❑ Spina Bifida
- ❑ Stroke/Brain Injury
- ❑ Other: _____

Cardiovascular

- ❑ Arteriosclerosis
- ❑ Asthma
- ❑ Chronic Obstructive Pulmonary
- ❑ Cystic Fibrosis
- ❑ Congestive Heart Failure
- ❑ Emphysema
- ❑ Heart Attack
- ❑ Peripheral Vascular Disease
- ❑ Thrombosis (Chronic)
- ❑ Other: _____

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Cognitive/Psychological

- ❑ Alzheimer's Disease
- ❑ Autism
- ❑ Dementia
- ❑ Head Trauma
- ❑ Panic Disorder
- ❑ Phobia
- ❑ Schizophrenia
- ❑ Other: _____

General Medical

- ❑ AIDS
- ❑ Diabetes (Severe)
- ❑ Cancer
- ❑ Lupus
- ❑ Epilepsy (Severe)
- ❑ Kidney Disease
- ❑ Skin Disorder
- ❑ Other: _____

Vision

Cataracts	❑ One	❑ Both	Retinal Detachment	❑ One	❑ Both
Glaucoma	❑ One	❑ Both	Retinopathy	❑ One	❑ Both
Legally Blind	❑ One	❑ Both	Totally Blind	❑ One	❑ Both
Muscular Degeneration	❑ One	❑ Both	Other: _____		

2. What disability prevents the applicant from riding the regular bus system? A detailed diagnosis is required. Please be as specific as possible without using diagnostic codes.

_____

_____

_____

_____

3. Describe how this disability affects the applicant's functional ability to ride the regular bus system:

_____

_____

_____

_____

4. Is this condition permanent or temporary? If temporary, what is the expected duration?

_____

_____

_____

_____

5. Does the applicant's disability require that he/she travel with an attendant?

❑ Yes ❑ No ❑ Sometimes (Please Explain Below):

_____

_____

_____

6. Is the applicant able to travel to and from a bus stop? ❑ Yes ❑ No (if no, please indicate all that apply)

❑ Cannot negotiate if the street or sidewalk is too steep.

❑ Cannot travel if there are no curb cuts.

❑ Cannot cross busy streets and intersections.

❑ Cannot tolerate extreme temperatures.

❑ Cannot locate bus stop due to a visual impairment.

❑ Cannot wait outside without support for 15 minutes.

❑ Becomes confused easily and may get lost

❑ Other: _____

7. Indicate the individual's ability to independently perform the following functions using the most effective mobility aid.

	Little to no difficulty	Discomfort and some difficulty	Severe pain and difficulty	Impossible and likely to cause medical crisis
Find own way home between familiar locations				
Handle money or tickets				
Provide address and telephone numbers upon request				
Recognize a destination or landmark				
Ask for, understand, and follow directions				
Travel 200 feet (city block)				
Travel 1/4 mile (three blocks)				
Deal with unexpected situations or unexpected changes in routine				
Safely and effectively travel through crowds and complex facilities				

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Applications with illegible or incomplete information will be returned.
Please use medical office stamp if available.

Person Completing Certification: _____

Professional Title: _____

Business Address: _____

Clinic or Agency: _____

Business Telephone: _____

I verify that the information provided for verification is true and correct.

_____	_____	_____
(Signature)	**(Printed Name)**	**(Date)**