



**ACCESS Application**

**Request for Certification of ADA Paratransit Eligibility**

The information obtained in this certification process will only be used by the South Bend Public Transportation Corporation (TRANSPO) for the provision of transportation services. The information will not be shared with any other person or agency.

**Part A: Applicant Profile**

Please type or print.

Last name \_\_\_\_\_ First name \_\_\_\_\_ Initial \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Main Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Date of Birth (month/day/year) \_\_\_\_\_

**Emergency Contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Main Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

**FOR OFFICE USE ONLY**

Application received \_\_\_\_\_ Professional verification mailed \_\_\_\_\_

Professional Verification received \_\_\_\_\_

Application received with professional verification \_\_\_\_\_

Determination \_\_\_\_\_

Mobility Aid \_\_\_\_\_ PCA \_\_\_\_\_

Conditions \_\_\_\_\_

Determination mailed \_\_\_\_\_ Expiration Date \_\_\_\_\_ Card # \_\_\_\_\_

Renewal Mailed \_\_\_\_\_ Second notice \_\_\_\_\_ Final notice \_\_\_\_\_

## Part B: Paratransit Service Certification

### Disability or Health Condition Information

1. What is the nature of your disability or health condition? (Be specific)

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2. Is your condition temporary?  Yes  No

If temporary, how long do you expect it to last? \_\_\_\_\_

3. Does your disability or health condition change from time-to-time in ways which affect your mobility?  Yes  No

If yes, please describe.

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### Mobility Information

1. Which of these mobility aids or equipment do you use to help get you where you need to go? (Check all that apply to you)

- |  |   |                                   |
|--|---|-----------------------------------|
| <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Powered Wheelchair/Scooter | <input type="checkbox"/> Crutches |
| <input type="checkbox"/> Cane              | <input type="checkbox"/> Service Dog                | <input type="checkbox"/> Walker   |
| <input type="checkbox"/> Other _____       |   | <input type="checkbox"/> None     |

2. Do you require a Personal Care Attendant when using Paratransit?

- Yes  No

3. Can you travel 3 blocks without assistance from another person?

- Yes  No

4. Can you climb three 12-inch steps without assistance from another person? 3

- Yes  No

5. Can you wait outside without support for 10 minutes?

- Yes  No

6. Can you communicate with a bus driver with or without an aid (such as a picture board or route ID cards)?  Yes  No

7. Do you ride the fixed route Transpo buses?

- Yes, regularly
- Yes, occasionally
- No, but I used to ride the bus
- No

8. Are there any other conditions which limit your ability to use the regularly scheduled buses?

- Yes
- No

If yes, please explain \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Applicant Verification**

**Applicant Signature**

I certify that the information given in this application is true and correct. I understand that falsifying of information may result in denial of service. I understand all information will be kept confidential and only the information required to provide service will be disclosed to those who perform such service. I understand that for confirmation, Transpo may contact the health care professional who completed the professional verification form attached to this application.

Applicant Signature \_\_\_\_\_

Date \_\_\_\_\_

**Person completing form (if other than applicant)**

I certify that the information provided in this application is true and correct based on either the information given to me by the applicant or upon my knowledge of the applicant's health condition or disability.

Name \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Daytime Phone \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_



## Part C: Professional Verification

Note: This portion must be completed by one of the following currently licensed professionals: registered nurse, physician, social worker, psychologist, physical therapist, chiropractor, occupational therapist, speech pathologist, nurse practitioner, physician's assistant, mental health counselor, orientation/mobility specialist, respiratory therapist, vocational rehabilitation counselor, or recreation therapist employed by a medical facility.

Dear Professional:

The Americans with Disabilities Act (ADA) of 1990 is a civil rights bill which bans discrimination against people with disabilities. In accordance with the act, Transpo provides complimentary paratransit (origin to destination) service for people who cannot access the regularly scheduled fixed route system.

Passengers must be certified eligible to use this service. Applicants may be found eligible for paratransit bus service for all trips they request, eligible (based on functional ability) for some trip requests but not for others, or capable of using the fixed route service. (Note: Transpo buses are equipped with kneelers which lower the buses closer to the ground, making it easier to step up into the bus. They are also equipped with wheelchair ramps and areas to tie them down near the front of the bus.) For those who can use the regular fixed route system, Transpo handicards are available for half-price fares.

The information you provide along with the applicant's information will enable us to make an appropriate determination for eligibility and for each trip request. All information will be kept confidential.

Thank you for your Assistance.

### **Disability of Health Condition information**

1. What is the nature of the applicant's disability or health condition? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Is the condition Temporary?  Yes  No

If temporary, how long do you expect it to last? \_\_\_\_\_

3. Does the applicant's disability or health condition change from time-to-time in ways which affects his or her mobility?  Yes  No

If yes please describe \_\_\_\_\_  
\_\_\_\_\_

4. If the applicant's disability affects his or her cognitive skills, please answer the following:

Can the applicant:

Give his or her phone number upon request?  Yes  No

Recognize landmarks and/or destinations?  Yes  No

Ask for, and follow, directions?  Yes  No

Safely travel through crowded facilities?  Yes  No

**Mobility Information**

1. Does the applicant use any type of mobility aid?  Yes  No

If yes, what type of aid? \_\_\_\_\_

2. Does the applicant travel with a personal care attendant (PCA)?

Yes  No  Sometimes

If sometimes, please explain \_\_\_\_\_

3. Using a mobility aid or with a PCA can the applicant travel three blocks?

Yes  No  Sometimes

4. Using a mobility aid or with a PCA, can the applicant climb three 12-inch steps?

Yes  No  Sometimes

Exceptions or additions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

Your name (print) \_\_\_\_\_ Title \_\_\_\_\_

Agency/Clinic \_\_\_\_\_

Phone number \_\_\_\_\_ Fax number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_