

Request for Paratransit Eligibility Certification under the Americans with Disabilities Act

If you are completing this form on a computer, click "Submit" on the last page to return it by e-mail. You may also return it to CCRPA, ATTN: Paratransit Application, 225 North Main St., Suite 304, Bristol, CT 06010-4993 or fax it to (860) 589-6950. If you have any questions, please call us at (860) 589-7820 or (860) 348-5610.

ALL QUESTIONS MUST BE COMPLETELY ANSWERED.
INCOMPLETE APPLICATIONS WILL BE REJECTED.

Certification

Please read the following paragraph and sign below. (Typed signatures are acceptable.)

I understand that the purpose of this application is to determine if there are times when I cannot use the public city buses (CTTransit) and must therefore use the ADA Paratransit Service. I understand that any information about my disability in this application will be kept confidential and shared only with professionals involved in providing this service. I certify that, to the best of my knowledge, the information in this application is true and correct. I understand that providing false or misleading information may result in re-evaluation of my eligibility.

Signature of applicant/guardian _____ Date _____

Your contact information

Last Name _____ First Name _____

Address _____ Apt./Bldg. # _____

City _____ State _____ Zip _____

Is this a temporary residence? Yes No

Is this a Licensed Nursing Care Facility? Yes No

If yes, name of facility _____

Date of Birth (MDY) ___/___/___

Sex Male Female

Telephone (daytime) _____ (evening) _____

TDD/Relay # (if applicable) _____

Please give us the name and telephone number of someone we can call in an emergency or if we are unable to reach you at your regular number:

Name _____ Relationship _____

Telephone (home) _____ (work) _____

Agency (if applicable) _____

If someone assisted you in completing this application, please provide us with that person's name and telephone number below:

Name _____ Relationship _____

Telephone (home) _____ (work) _____

Agency (if applicable) _____

How did you hear about our services? _____

Your public bus experience

1. *Do you ride the public city bus (CTTransit)?*

Yes No Sometimes

2. *When was the last time you used the public city bus (CTTransit)?*

3. *Could you use the public city bus (CTTransit) if you had information on routes and times?*

Yes No Sometimes

4. *Travel Training is a free service that assists people with disabilities to learn how to ride and use the public city bus (CTTransit) service. Would you like more information?*

Yes No I need information in accessible formats

5. *Are you eligible to use medical or other transportation services?*

(e.g., Medicaid, Social Services, etc.)

Yes No Don't Know

Your functional ability

Can you get on and off a public city bus (CTTransit)?

Yes, I can climb steps

I probably could with instruction

Yes, I can use the lift and/or ramp

No (explain) _____

For each statement, check one answer. Your answer should be based on how you feel most of the time under normal circumstances and whether you can perform this activity.

I can cross the street if there are curb cuts.

Yes

No

Sometimes

I can travel up/down a gradual hill in good weather conditions.

Yes

No

Sometimes

I can find my way to the public city bus (CTTransit) stop if someone shows me once.

Yes

No

Sometimes

I am able to wait for 10 minutes at a public city bus (CTTransit) stop that does not have seats and a shelter.

Yes

No

Sometimes

I am able to ask for, understand, and follow directions.

Yes

No

Sometimes

I am able to detect curbs, ramps, and other drop off areas.

Yes

No

Sometimes

Answer the following questions by checking all that apply. What barriers in your surroundings make it difficult for you to use the public city bus (CTTransit)?

- | | |
|-------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Lack of curb cuts | <input type="checkbox"/> Sidewalks are in poor condition |
| <input type="checkbox"/> No sidewalks | <input type="checkbox"/> Busy streets I must cross |
| <input type="checkbox"/> Steep hills | <input type="checkbox"/> No crosswalks at street corners |
| <input type="checkbox"/> Other (describe) _____ | |

Your medical condition

What type of disability prevents you from using the public city bus (CTTransit) system?
Check all that apply.

- | | |
|-----------------------------------|----------------------------------------|
| <input type="checkbox"/> Physical | <input type="checkbox"/> Cognitive |
| <input type="checkbox"/> Visual | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> None |
| <input type="checkbox"/> Other | |

Identify disabilities by name _____

Please describe your disability in detail _____

Is this condition temporary? Yes No

If yes, expected duration _____

Do you require the assistance of a Personal Care Attendant (PCA)?

Yes No Sometimes

Do you use any of the following devices? Check all that apply.

- | | | |
|-------------------------------------|-----------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Cane | <input type="checkbox"/> Manual wheelchair* | <input type="checkbox"/> Oxygen tank |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Electric wheelchair* | <input type="checkbox"/> Service animal |
| <input type="checkbox"/> Braces | <input type="checkbox"/> Power scooter* | <input type="checkbox"/> None |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Communication board | |
| <input type="checkbox"/> White cane | | |

Authorization to obtain physician/other professional verification

In order to evaluate your request, it may be necessary to contact your physician or other professional to confirm the information you have provided. Please complete the following information and authorization form.

Physician Health Care Professional Rehabilitation Professional

The following professional is familiar with my disability and is to provide the required needed information to the Central Connecticut Paratransit Service to complete my certification for ADA Paratransit Service.

Professional's Name _____

Agency or Practice _____

Office Address _____

City _____ State _____ Zip _____

Professional's Telephone _____ Fax _____

Applicant's Name _____ Date of Birth (MDY) ____/____/____

Signature of applicant/guardian _____ Date _____

If you cannot submit this application with the button below, please save this PDF to disk and attach it to an e-mail to apply@busoncall.com.

Definition of ADA Regulations

Any person with a disability who is unable, as a result of a physical or mental impairment, and without the assistance of another individual, (except the operator of a wheelchair lift) to board, ride, or disembark from any public city bus. Any person with a disability who has a specific impairment-related condition which prevents them from traveling to or from a bus stop on the public city bus system. Architectural and environmental barriers such as distance, terrain or weather; do not, standing alone, form a basis for eligibility. However, a person may be eligible if the interaction of the disability and barriers prevent the person from traveling to or from the public city bus stop.

* A common wheelchair is any device that has three or four wheels operated manually or powered. It should not exceed 30 inches in width, 48 inches in length, and 600 pounds when occupied and certified for use.