

REQUEST FOR CERTIFICATION OF ADA PARATRANSIT ELIGIBILITY

- PART A-

1. Name _____

2. Address _____

3. Telephone Number (home) _____ (work) _____

4. Date of Birth ____/____/____

5. What is the disability which prevents you from using our fixed route service? _____

6. How does this disability prevent you from using fixed route services? Please explain completely. Use an additional sheet if needed. _____

7. Are there any other effects of your disability of which we need to be aware? _____

THE FOLLOWING INFORMATION WILL BE USED TO ENSURE THAT AN APPROPRIATE VEHICLE IS UTILIZED TO PROVIDE YOUR TRANSPORTATION AND THAT AN ACCURATE ANALYSIS OF YOUR TRIP REQUESTS CAN BE MADE BY THE MICHIGAN CITY MUNICIPAL COACH.

8. Do you use any of the following aids to mobility? (check all that apply)

Manual Wheelchair _____

Electric Wheelchair _____

Cane _____

Crutches _____

Powered Scooter _____
Personal Care Attendant _____

Guide Dog _____

9. Do you require a Personal Care Attendant when you travel using transit?

Yes _____ No _____

10. Please Answer to following questions:

Can you travel 200 feet without the assistance of another person?

Yes _____ No _____ Sometimes _____

Can you travel 1/4 mile without the assistance of another person?

Yes _____ No _____ Sometimes _____

Can you climb three 12-inch steps without assistance?

Yes _____ No _____ Sometimes _____

Can you wait outside without support for ten minutes?

Yes _____ No _____ Sometimes _____

11. I hereby certify that the information given above is correct.

Signed _____ Date ____/____/____

12. If this application has been completed by someone other than the person requesting certification, that person must complete the following:

Name _____

Address _____

Daytime Phone _____

Signed _____ Date ____/____/____

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

The following Physician _____ Health Care Professional _____ Rehabilitation Professional _____ (check one) is familiar with my disability and is authorized to provide information to the Michigan City Municipal Coach required to complete this certification.

Name _____

Address _____

Phone Number _____

Print Name _____ Date of Birth ____/____/____

Signed _____ Date ____/____/____

REQUEST FOR PROFESSIONAL VERIFICATION

- PART B-

Dear _____,

The attached authorization form has been submitted by _____, who has indicated that you can provide information regarding his/her disability and its impact upon his/her ability to utilize our transit services. Federal law requires that the Michigan City Municipal Coach provide paratransit services to persons who cannot utilize available fixed route services. The information you provide will allow us to make an appropriate evaluation of this request and its application to specific trip requests. Thank you for your cooperation in this matter.

Capacity in which you know this applicant:

Medical diagnosis of condition causing disability:

Is the condition temporary?

Yes _____ No _____ Expected duration until _____/_____/_____

If the person has a disability effecting mobility:

Is the person:

Able to walk 200 feet without assistance? Yes _____ No _____ Sometimes _____

Able to walk 1/4 mile without assistance? Yes _____ No _____ Sometimes _____

Able to climb three 12-inch steps without assistance? Yes _____ No _____ Sometimes _____

Able to wait outside without support for 10 minutes? Yes _____ No _____ Sometimes _____

Does this person use any mobility aids? if so, what?

If this person has a visual impairment:

Visual Acuity with Best Correction:

Right Eye _____ Left Eye _____ Both Eyes _____

Visual Fields:

Right Eye _____ Left Eye _____ Both Eyes _____

If the person has a cognitive disability:

Is the person able to:

Give address and telephone numbers upon request? Yes _____ No _____

Recognize a destination or landmark? Yes _____ No _____

Deal with unexpected situations or unexpected change in routine? Yes _____ No _____

Ask for, understand and follow directions? Yes _____ No _____

Safely and effectively travel through crowded and/or complex facilities? Yes _____ No _____

Is there any other effect of the disability of which the Michigan City Municipal Coach should be aware of?
Please describe.

Your Name: _____

Office Address: _____

Office Phone Number: _____

Signature: _____