

**REQUEST FOR CERTIFICATION OF ADA  
PARATRANSIT ELIGIBILITY**

**-- PART A --**

The information obtained in this certification process will only be used by MC Transit for the provision of transportation services. Information will only be shared with other transit providers to facilitate travel in those areas. The information will not be provided to any other person or agency.

1. Name \_\_\_\_\_

2. Address \_\_\_\_\_

\_\_\_\_\_

3. Phone 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 for which we need to be made aware? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**-- PART A --**

The following information will be utilized to ensure that an appropriate vehicle is used when providing your transportation and that an accurate analysis of trip requests can be made by the MC Transit.

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

- Manual Wheelchair \_\_\_\_\_ Cane \_\_\_\_\_
- Electric Wheelchair \_\_\_\_\_ Crutches \_\_\_\_\_
- Powered Scooter \_\_\_\_\_ Guide Dog \_\_\_\_\_
- Personal Care Attendant \_\_\_\_\_

9. If you would like a Personal Care Attendant when you travel using transit?  
Yes \_\_\_\_\_ No \_\_\_\_\_

10. Please answer the following questions:

Can you travel 200 feet 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 the above information 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 \_\_\_\_\_

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

**-- PART A --**

In order to allow the MC Transit 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 MC Transit as required to complete this certification.

Name of Health Care Provider \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Applicant's Printed Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Applicant's Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**REQUEST FOR PROFESSIONAL VERIFICATION**

**-- PART B --**

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 the MC Transit to 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 the applicant: \_\_\_\_\_

Medical Diagnosis of condition causing disability: \_\_\_\_\_

Is the condition temporary?

No \_\_\_\_\_ Yes \_\_\_\_\_ Expected duration until \_\_\_/\_\_\_/\_\_\_

If the person has a disability affecting mobility:

Is the person able to walk 200 feet without assistance? No \_\_\_ Yes \_\_\_  
Sometimes \_\_\_\_\_

Able to walk 1/4 mile without assistance? No \_\_\_\_\_ Yes \_\_\_\_\_  
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 \_\_\_\_\_

**-- PART B --**

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

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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 addresses 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 for which the MC Transit should be made aware? Please describe.

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Your Name \_\_\_\_\_

Office Address \_\_\_\_\_

Office Phone Number \_\_\_\_\_

Signature \_\_\_\_\_