ADA Paratransit Application

Please mail, email or fax your completed application to:

Michiana Area Council of Governments (MACOG)
227 W. Jefferson Blvd.
1120 County-City Building
South Bend, IN 46601

Phone: (574) 674-8894
Fax: (574) 239-4072
E-mail: macogdir@macog.com

Revised 1/26/2016

Overview

The purpose of this application is to provide an opportunity for you to describe how your disability prevents you from being able to ride the Interurban Trolley system.

If you have difficulty answering any questions on the application or if you need assistance completing this form, please call MACOG at (574) 674-8894. Please complete this application as thoroughly as possible. Note that the application is printed on both sides of each page. The more complete and accurate information you provide, the better MACOG will understand your abilities and travel challenges. If a question does not apply to you, please write "Not applicable" or "N/A".

Information contained in this application will be kept confidential and shared with the professionals involved in the evaluation of your eligibility for MACOG or others designated on the Application Certification and the Authorization to Release Medical Information forms.

MACOG will mail you an eligibility determination within 21 days of the date that MACOG receives your application.

Appeal Process

Persons whose application is not found eligible may appeal the decision in writing, within 60 days of the date of their determination letter. Send appeals to:

Michiana Area Council of Governments (MACOG)
227 W. Jefferson Blvd.
1120 County-City Building
South Bend, IN 46601

The Elkhart/Goshen Transit Advisory Committee will review the eligibility documentation and make a final decision on eligibility status. This review will be concluded within twenty-one working days of the date the appeal was received. The person making the appeal has the right to appear at this review.

PART A – Contact Information

Please Print:

Last Name First Name Middle Name

Home Address:

Address

City Zip Code

Mailing Address (If different from Home Address):

Address

City Zip Code

Contact Information:

Daytime Phone Evening Phone Cell Phone

Fax Email

Personal Information:

☐ Male ☐ Female Date of Birth: ____/____/____
MM DD YYYY

Emergency Contact:

Name Relationship

Daytime Phone Evening Phone Cell Phone

PART B – Paratransit Service Certification

Please answer the following questions in detail – your specific answers to the questions will help us in determining your eligibility.

Disability or Health Condition Information

1. Please specifically name disabilities or health related conditions that **PREVENT** you from using the Interurban Trolley public transit system.

   _____
   _____
   _____
   _____

2. Briefly explain **HOW** your disabilities or health related conditions prevent you from using the Interurban Trolley public transit system.

   _____
   _____
   _____
   _____

3. Do the conditions you describe change from day to day in a way that affects your ability to use public transit?
   - ☐ Yes, good on some days, bad on others.
   - ☐ No, doesn't change.
   - ☐ Don't know

4. Are the conditions you described:
   - ☐ Permanent
   - ☐ Temporary
   - ☐ Don't know

   If temporary, how long do you expect these conditions to continue?

   _____
   _____

PART B – Paratransit Service Certification

5. Do your disabilities or health related conditions prevent you from understanding bus schedules, paying fares, transferring buses, or when to get on or off the bus?
   ☐ Yes ☐ No

6. Do your disabilities or health related conditions prevent you from easily seeing steps and curbs, route names on buses, or trolley stop signs?
   ☐ Yes ☐ No

Mobility Information

1. Do you use any of the following mobility aids or specialized equipment? *(Check all that apply)*

☐ Cane	☐ Power Wheelchair	☐ Manual Wheelchair
☐ White Cane	☐ Service Animal	☐ Communication Devices
☐ Power Scooter	☐ Crutches	☐ Walker
☐ Leg Braces	☐ Prosthesis	☐ Portable Oxygen Tank
☐ Other Aid: _____		

Required of all wheelchair users:

Height of Wheelchair: _____

Width of Wheelchair: _____

Weight of Wheelchair: _____

Combined Weight of Applicant & Wheelchair: _____

PART B – Paratransit Service Certification

2. Do you travel with the help of another person?

   ☐ Always ☐ Sometimes ☐ Never

   If always or sometimes, what type of help do they provide?

   _____

3. Can you travel 3 blocks with your usual mobility aid and without the assistance from another person?

   ☐ Yes ☐ No

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

   ☐ Yes ☐ No

5. Can you wait outside without a seat or shelter for 10 minutes, if the weather is good?

   ☐ 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. Can you travel up or down a gradual hill on the sidewalk, if the weather is good?

   ☐ Yes ☐ No

8. Can you cross the street, if there are curb cuts?

   ☐ Yes ☐ No

9. Do you ride the Interurban Trolley public transit system?

   ☐ Yes, regularly

   ☐ Yes, occasionally

   ☐ No, I have never used the Interurban Trolley

   ☐ No, not since the onset of my disability

PART B – Paratransit Service Certification

10. Are you able to get to and from the bus stop nearest your home?

☐ Yes ☐ No ☐ Sometimes ☐ Don't know, never tried it

If no or sometimes, explain why:

_____

_____

11. Are you able to grasp handles, railings, coins, or tickets while boarding or exiting a transit vehicle?

☐ Yes ☐ No ☐ Sometimes ☐ Don't know, never tried it

If no or sometimes, explain why:

_____

12. Are you able to maintain balance and tolerate movement of a public transit vehicle when seated?

☐ Yes ☐ No ☐ Sometimes ☐ Don't know, never tried it

If no or sometimes, explain why:

_____

_____

13. Would you be able to get on or off a public transit bus if it has a lift, ramp, or a kneeler that lowers the front of the bus?

☐ Yes ☐ No ☐ Sometimes ☐ Don't know, never tried it

If no or sometimes, explain why:

_____

_____

14. Please add any other information that you would like us to know about your mobility.

_____

_____

_____

Applicant Certification

I certify that I have been truthful in answering this form and that the information that I have provided is correct. I understand that the purpose of this application is to determine if I am eligible to ride the paratransit system. I understand that knowingly falsifying the information will result in denial of service. I understand all information will be kept confidential, and only the information required to provide services I request will be disclosed to those who perform the services.

I understand that an eligibility determination will be made within 21 days of the date that MACOG receives my application. I understand that if my application is not found eligible, that I may appeal such determination within 60 calendar days and that I will be advised of the procedures for such an appeal.

I understand that it may be necessary to contact a professional familiar with my functional abilities to use public transit in order to assist in the determination of eligibility.

Applicant's signature: _____ Date: _____

Did someone help you in filling out this form? ☐ Yes ☐ No

If yes, Name: _____ Phone: _____

Relationship to Applicant: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone: _____

Signature: _____ Date: _____

PART C - Healthcare/Social Service Professional Verification

In order for MACOG to evaluate your request, it may be necessary to contact a professional to confirm the information you have provided or to answer any additional questions about your functional abilities to ride public transit. Please identify a person who could document your disability by completing the following information and authorization form.

The following professional is **most familiar with my disability and my functional abilities to ride public transit** :

_____

Professional's First and Last Name

_____

Address

_____

City Zip Code

_____ _____ _____

Phone Fax Email

Check the appropriate box to identify professional relationship:

- ☐ independent living specialist
- ☐ chiropractor
- ☐ mental health counselor
- ☐ nurse practitioner
- ☐ occupational or physical therapist
- ☐ ophthalmologist or optometrist
- ☐ orientation and mobility specialist
- ☐ other: _____
- ☐ physician
- ☐ physician's assistant
- ☐ psychologist or psychiatrist
- ☐ registered nurse
- ☐ rehabilitation counselor
- ☐ social worker
- ☐ vocational rehab. counselor

I authorize the release of required information to MACOG for certification.

Applicant's signature: _____ Date: _____

PART C - Healthcare/Social Service Professional Verification

ADA Paratransit Application

Dear Professional:

Your client/patient is requesting eligibility for The Interurban Trolley's Americans with Disabilities Act (ADA) Paratransit service. Your professional relationship with this applicant uniquely qualifies you to help clarify his or her functional abilities and limitations. These guidelines may help you understand the type of information we need in order to determine the applicant's eligibility for paratransit.

ADA paratransit eligibility is based not just on the presence of a disability, but on the effect that the disability has on the person's ability to use the fixed route service. The eligibility determination focuses solely on:

- **Functional ability** to independently perform the tasks necessary for bus use including: getting to and from the bus stop, getting on the bus, riding the bus, and understanding how to navigate the system in a variety of environments. A diagnosis by itself does not qualify an individual for paratransit service eligibility.

- Whether the individual is **prevented** and **unable** from performing these tasks, as opposed to the task being more inconvenient or difficult.

- Whether the individual can perform these tasks all of the time, only under some circumstances, or if the disability would always prevent the individual from performing these tasks.

Please note that all fixed route buses are equipped with lifts or ramps. Fixed route buses offer accessibility features like priority seating for seniors and individuals with disabilities, secure wheelchair tie-downs, etc.

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

Thank you for your assistance. If you have any questions, please feel free to **call us at (574) 674-8894**.

PART C - Healthcare/Social Service Professional Verification

Applicant's Name: _____ Date of Birth: _____

1. In what capacity do you know the applicant?

   _____

   _____

2. How long have you known the applicant?

   _____

3. When was the last appointment you or your agency had with the applicant?

   _____

4. Please describe the nature of the disabilities or health related conditions that **PREVENT** the applicant from using the Interurban Trolley public transit system:

   _____

   _____

   _____

   _____

   _____

5. Briefly explain **HOW** the applicant's condition prevents them from using the Interurban Trolley public transit system.

   _____

   _____

   _____

6. Are the applicant's conditions described above:

   ☐ Permanent ☐ Temporary

   If temporary, how long do you expect these conditions to continue?

   _____

   _____

7. Does the applicant's disability or health condition change from time-to-time in ways that affect his or her mobility?

   ☐ Yes ☐ No

   If Yes, please describe:

   _____

   _____

PART C - Healthcare/Social Service Professional Verification

8. 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 in the community?	☐ Yes	☐ No
Problem solve in unexpected situations?	☐ Yes	☐ No
Clearly communicate needs?	☐ Yes	☐ No

9. Does the applicant use any type of mobility aid?

   ☐ Yes ☐ No

   If Yes, what type of aid:

   _____

   _____

10. Does the applicant travel with a personal care attendant?

    ☐ Yes ☐ No ☐ Sometimes

    If Yes or sometimes, please describe:

    _____

    _____

11. If this applicant is currently on medication(s), will the side effects of this significantly reduce or hinder their ability to independently ride the accessible Interurban Trolley system?

    ☐ Yes ☐ No

    If Yes, please describe:

    _____

    _____

12. Would extremes in temperature affect this applicant's ability to ride the accessible Interurban Trolley system?

    ☐ Yes ☐ No

    If Yes, please describe:

    _____

    _____

PART C - Healthcare/Social Service Professional Verification

13. In your professional opinion what other factors related to the applicant's disabilities affect his or her ability to ride the Interurban Trolley public transit system?

_____
_____
_____
_____
_____

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

Your Name: _____ Title: _____

Agency or Clinic: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____

Please mail, email or fax your completed form to:

Michiana Area Council of Governments (MACOG)
227 W. Jefferson Blvd.
1120 County-City Building
South Bend, IN 46601
Phone: (574) 674-8894
Fax: (574) 239-4072
E-mail: macogdir@macog.com