

APPENDIX B

ADA Complementary Paratransit Application Form

**TWIN CITIES AREA TRANSPORTATION  
AUTHORITY**

**275 E. WALL ST.  
BENTON HARBOR, MI 49022**

**ADA Complementary Paratransit Application**

Name \_\_\_\_\_ Birth Date \_\_\_/\_\_\_/\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_

Number Street Apt #

City State Zip Code

**Mailing Address (if different than above)**

Number Street Apt #

City State Zip Code

**E-Mail Address** \_\_\_\_\_

<b>FOR OFFICE USE ONLY</b>			
Alternate Format	N T B L P E	Certification	C U
Applic. Rec'd.	_____	Mob Device	_____
Determination Due	_____	Expiration	_____
Med. Ref. Req.	_____	Letter Sent	_____
Med. Ref. Rec'd.	_____	Jurisdiction	_____
ID #	_____		
Disability Type	_____	Disability Description	_____ PCA?
Yes	___	No	___

**Do you manage your own affairs and deal with your own mail?**

Yes  No

**If no, to whom should important correspondence be mailed?**

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

**Address** \_\_\_\_\_  
Number Street Apt #

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

**Phone** (\_\_\_\_) \_\_\_\_\_

**Emergency Contact:** This is a person who is authorized to make day-to-day and/or emergency decisions regarding service for the applicant. (In most cases this will be a provider or family member)

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

**Home Phone** (\_\_\_\_) \_\_\_\_\_ **Cell Phone** (\_\_\_\_) \_\_\_\_\_

## Introductions and Instructions

Twin Cities Area Transportation Authority (TCATA) is **your** public transit system. Our mission is to provide the community with public transportation services that are dependable, convenient, safe, cost effective, and **accessible for all**.

TCATA provides three transportation services: Demand Response (door- to-door), Fixed Route bus service, and a paratransit service for individuals who are unable to use the Fixed Route bus system some or all the time (6am-10pm).

**To determine whether you are eligible for TCATA paratransit service, we need to know if there is any part of the regular accessible bus system you cannot use due to your disability. Eligibility is not based on the disability itself, but on how it prevents you from using the regularly accessible bus routes.** It is possible for you to be eligible for some trips, but not others. If this is the case, you will be paratransit eligible *with conditions*, the conditions being the circumstances preventing your use of the accessible bus system.

### **ADA paratransit eligible individuals fall into one of the following definitions:**

- Any individual with a disability who is unable, as the result of a physical or mental health or psychiatric disability (including a visual disability), to board, ride, or disembark from a fixed-route vehicle on TCATA.
- Any individual with a disability who needs the assistance of a wheelchair lift or other boarding assistance device and is able, with such assistance, to board, ride, or disembark from any vehicle, and one is not available on the route.
- Any individual with a disability who has a specific disability-related condition which prevents the individual from traveling to a boarding location or from a disembarking location served by the fixed-route system.

This application will help TCATA determine whether you qualify for paratransit service according to the criteria noted above. Return your completed application to: **Twin Cities Area Transportation Authority, 275 E. Wall St., Benton Harbor, MI 49022**; you will need to apply postage. Completed applications can also be **faxed** to TCATA at **269-927-2310**.

(3) The enclosed Physician or Agency Professional Verification form asks you to designate the health care or human service professional that is most familiar with your "ability to travel." The person you designate could be a doctor, physical or occupational therapist, human service professional (such as a social worker), who is very familiar with your mobility. TCATA may contact that person to verify your mobility limitations.

If approved, your certification will be for a 3-year period. Two months prior to the end of that 3-year period, you will be notified and provided with a Certification Renewal form.

When TCATA receives your **completed** application, it will be reviewed for eligibility. You will receive written notification within 21 days if your application is approved, approved with conditions, or denied. If your application is approved with conditions or not approved, your notification will state the reasons for the decision. You have a right to appeal your eligibility determination and have an opportunity to provide additional information for reconsideration. Eligibility appeals shall not be handled by someone who made the original decision.

Appeals must be made within 90 days of receiving notification of an application being approved with conditions or not approved. If no decision is made with 30 days of completing the appeal process, the applicant shall be treated as eligible and provided service until and unless TCATA denies the application. You will receive additional details about the appeal process with your letter.

**If you have any questions about this form or need it provided in a different format, please call TCATA at (269) 927-2268.**

*The information obtained in this certification process will only be used by TCATA for the provision of ADA complementary paratransit service. Information will only be shared with other transit providers to facilitate your travel in their operating areas, should you so desire. This information will not be provided to any other person or agency and will be kept strictly confidential.*

**Please be sure to complete all parts of this application; applications cannot be processed unless all questions are completed. Be sure to complete the front cover with the applicant's personal information.**

## **Applicant Questionnaire**

Do you need this application and future written information provided in a different format?

\_\_\_\_\_ Yes      \_\_\_\_\_ No

If Yes, specify below or call **(269) 927-2268**.

\_\_\_\_\_ Large Print (Font size needed \_\_\_\_\_)      \_\_\_\_\_

Other Language (e.g. Spanish)

Audio

Other \_\_\_\_\_

Email \_\_\_\_\_

***If you do not need a different application format, please continue to the next section***

**Contact Information**

Name \_\_\_\_\_ Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
mm/dd/yyyy

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_  
Number Street Apt #

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

**Mailing Address (if different than above)**

\_\_\_\_\_  
Number Street Apt #

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

**E-Mail Address** \_\_\_\_\_

Do you manage your own affairs and deal with your own mail?  Yes  No If

no, to whom should important correspondence be mailed?

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

Address \_\_\_\_\_

Number

Street

Apt #

\_\_\_\_\_ City

\_\_\_\_\_ State

\_\_\_\_\_ Zip Code

Phone (\_\_\_\_\_) \_\_\_\_\_

**Emergency Contact:** This is a person who is authorized to make day-to-day and/or emergency decisions regarding service for the applicant. (In most cases this will be a provider or family member)

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

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

**FIXED-ROUTE SERVICE** *Please answer the following questions:*

**Do you currently use Fixed Route TCATA buses?**

- Yes (*Checking yes will not disqualify you from receiving paratransit services*).
- No (*If no, answer next question*):

**If No, which of the following limit your ability to use fixed-route buses (check all that apply):**

- Physical disability
- Visual disability
- Developmental disability
- Mental health/psychiatric disability
- Other (indicate)\_\_\_

**What would help you ride the fixed-route buses? (Check all that apply):**

- Knowing more about fixed-route buses.
- Learning to travel in the community.
- A lift or ramp (accessible bus).
- Communications aid
- Other (indicate)\_\_\_

**Can you follow written or oral instructions to use the fixed-route buses? (check all that apply):**

- Yes, always
- Yes,
- sometimes
- No
- I do not know, because I have never tried it.
- I get too confused and might get lost.

I probably could with training.

Other (indicate) \_

**Do you know where to get on/off the bus? (Check all that apply):**

Yes, always

Yes, sometimes

No

I get confused or cannot remember where I am going.

I do not know where my bus stop is located.

I can if the driver calls out the stops.

I probably could with training.

Other (indicate) \_\_\_\_\_

**Does the weather ever keep you from using fixed-route buses?**

Yes. (Tell us how the weather keeps you from using fixed-route buses):

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No

I do not know.

**Does any of the following keep you from using the fixed-route buses?**

**(Check all that apply):**

There are no sidewalks (Please tell us where)

\_\_\_\_\_

The sidewalks are not accessible or safe (Please tell us where)

\_\_\_\_\_

My mobility aid will not fit on the lift. \_\_\_\_\_

I cannot steady myself when the lift is moving.

I do not feel secure on the lift. \_\_\_\_\_

I probably could with training.

Other (indicate) \_

**Please explain as completely as possible how your disability prevents you from boarding, riding and exiting a regular fixed route bus.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**How would you best describe your disability or condition as it impacts your transportation needs?**

\_\_\_\_\_Permanent \_\_\_\_\_Deteriorating \_\_\_\_\_Changeable \_\_\_\_\_Temporary

If temporary, until what date: \_\_\_\_\_

**Are there other effects of your disability or condition that we need to be aware of to provide you with appropriate service?**

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**Which of these aids or equipment do you usually use to help you get where you need to go?**

- |                                     |  |  |
|-------------------------------------|--|--|
| <input type="checkbox"/> Cane       | <input type="checkbox"/> Manual Wheelchair   | <input type="checkbox"/> Personal Care Attendant |
| <input type="checkbox"/> White Cane | <input type="checkbox"/> Electric Wheelchair | <input type="checkbox"/> Power Scooter           |
| <input type="checkbox"/> Crutches   | <input type="checkbox"/> Walker              | <input type="checkbox"/> Other _____             |
| <input type="checkbox"/> Oxygen     | <input type="checkbox"/> Service Animal      | <input type="checkbox"/> None                    |

**Do you need a wheelchair accessible/lift equipped vehicle? (circle one)**

Yes \_\_\_\_\_ No

**If you use a manual or powered wheelchair or scooter, is it more than 30 inches wide, more than 46 inches long, or does it, when in use, weigh more than 800 pounds? (circle one)**

Yes                  No

**Do you ever need the assistance of another person to be able to travel? (circle one)**

Yes                  No                  Sometimes

**If Yes, when do you need help?**

- Getting to/from vehicle.
- Getting to the bus stop.

- Getting on or off the bus.
- Getting on or off the vehicle.
- Help while I ride the bus.
- Help to get to where I am going once, I am off the bus
- Other (indicate) \_\_\_\_\_

**What is the longest distance you can walk/travel on level ground without the assistance of another person? (Example 370 feet = 1 block)**

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**Is there any other information not covered in this application that you would like TCATA to consider when reviewing your eligibility for paratransit services?**

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**PHYSICIAN OR AGENCY PROFESSIONAL AUTHORIZATION**

Please provide the name, address, and contact information for your health care providers who can verify the information contained in this application.

Name \_\_\_\_\_

Address \_\_\_\_\_

Number

Street

Apt #

\_\_\_\_\_

City

\_\_\_\_\_

State

\_\_\_\_\_

Zip Code

Phone (\_\_\_\_\_) \_\_\_\_\_ Fax Number (\_\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Number

Street

Apt #

\_\_\_\_\_

City

\_\_\_\_\_

State

\_\_\_\_\_

Zip Code

Phone (\_\_\_\_\_) \_\_\_\_\_ Fax Number (\_\_\_\_\_) \_\_\_\_\_

I certify that the information I gave in this application is true and correct. Falsification of information may result in denial of service. I understand all healthcare information will be kept confidential except as needed for verification. Only the information required to provide the services I request will be disclosed to those who perform those services. I have read and agree to comply with the policies and procedures set forth by the Twin Cities Area Transportation Authority.

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

(If Applicant is a minor or incapable of signing this application, please complete page 6

**CERTIFICATION OF APPLICANT**

If someone has completed this application other than the person applying for certification, that person must complete the following:

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

I certify that the information provided in this application is true and correct based upon information given to me by the applicant.

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

Print Name \_\_\_\_\_

Daytime Phone (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

Number

Street

Apt #

\_\_\_\_\_ City

\_\_\_\_\_ State

\_\_\_\_\_ Zip Code

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

**Return completed application form to:**

Twin Cities Area Transportation Authority

Attn: ADA Coordinator

275 E. Wall St.

Benton Harbor, MI 49022

**Email:** [office@tcatabus.org](mailto:office@tcatabus.org)

*Please write Attn: ADA Coordinator in the subject line*

If you have any questions regarding completing this application form, the process for becoming certified, or need help completing the application, please **contact TCATA's ADA Coordinator at: (269) 927-2268.**