Expiration Date: _____ P- _____

Date of certification: _____

101 N. Jackson St. Danville, IL 61832
217-431-0653

ADA Paratransit Request for Certification

The information obtained in this certification process will be used by Danville Mass Transit for the provision of transportation services. Information will be considered confidential.

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Emergency phone: _____

Date of birth:_____

ADA paratransit service is provided to eligible passengers traveling within the Danville Mass Transit service area. Service area is defined as the area within ¾ of a mile of the fixed routes. ADA paratransit service is provided during the same hours of operation as the DMT fixed routes.

What is the disability which prevents you from using fixed route service?

_____

Is this condition temporary? No ___ Yes ___

If yes, it is expected to last through: _____
(date)

Do you use any of these mobility aids or equipment? ***(Check all that apply)***

☐ Cane	☐ Manual wheelchair	☐ Prosthesis	☐ Other, Please specify_____
☐ Crutches	☐ Power wheelchair	☐ Portable oxygen	
☐ Walker	☐ Power scooter	☐ Service animal	

Do you ever need to bring someone with you to help you when you travel (a "personal care attendant")?

☐ Yes, always ☐ Yes, sometimes ☐ No

Please answer the following questions about your abilities. <u>Without</u> the help of someone else, can you….

1. Climb three 12-inch steps if there is a handrail?
   ☐ Always ☐ Sometimes ☐ Never
2. Wait outside for 10 minutes?
   ☐ Always ☐ Sometimes ☐ Never
3. Give addresses and telephone numbers upon request?
   ☐ Always ☐ Sometimes ☐ Never
4. Ask for, understand, and follow directions?
   ☐ Always ☐ Sometimes ☐ Never
5. Deal with unexpected situations or unexpected change in routine?
   ☐ Always ☐ Sometimes ☐ Never
6. Get from the bus to the door of my destination?
   ☐ Always ☐ Sometimes ☐ Never

What is the FARTHEST you can walk (or travel using your mobility aid) without the assistance of another person?

☐ Less than 1 block ☐ 1 block ☐ 2 blocks (1/4 mile) ☐ More than 1/4 mile

How does your disability prevent you from using fixed route service? Please explain completely:

Does your condition/disability change from day-to-day, or season-to-season in ways that affect your ability to use the fixed route service? No _____ Yes _____

If yes, please explain:

Do you currently use fixed route buses at all?

☐ Always ☐ Sometimes ☐ Never

If you used fixed route buses in the past and have stopped using them, please explain why:

Would you like information about free training to use the fixed route buses?

☐ Yes ☐ No

Please complete the back of this form.

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

Name: _____

Address: _____

_____
City State Zip

The following physician ___, Health Care Professional ___, or Rehabilitation Professional ___ (check one) is familiar with my disability and is authorized to provide information required to complete this certification to Danville Mass Transit.

Name of professional to be contacted: _____

Professional's address: _____

_____
City State Zip

Professional's phone number: _____

I understand that the purpose of this application is to determine if I am eligible to use ADA Paratransit Services. I certify that the information provided in this application is true and correct.

Applicant's name _____
Please print

Applicant's signature _____

Date _____

REQUEST FOR PROFESSIONAL VERIFICATION OF ADA PARATRANSIT ELIGIBILITY

Date of Request: _____

This form is to be completed by a Health Care Professional.

The attached authorization form has been submitted by _____.
(Applicant's Name)

He/she has indicated that you can provide information regarding his/her disability and its impact upon his/her ability to utilize our transit services. Paratransit services are provided to eligible persons who cannot utilize available Danville Mass Transit 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.

Capacity in which you know the applicant: _____

Condition causing disability: _____

Is the condition temporary? No ___ Yes ____

If yes, it is expected to last through: _____

Does the applicant use any of these mobility aids or equipment? *(Check all that apply)*

- ☐ Cane
- ☐ Crutches
- ☐ Walker
- ☐ Manual wheelchair
- ☐ Power wheelchair
- ☐ Power scooter
- ☐ Prosthesis
- ☐ Portable oxygen
- ☐ Service animal
- ☐ Other, Please specify_____

Would the applicant ever need to take someone with them to help them when they travel (a "personal care attendant")?

☐ Yes, always ☐ Yes, sometimes ☐ No

What is the FARTHEST the applicant can walk (or travel using his/her mobility aid) without the assistance of another person?

☐ Less than 1 block ☐ 1 block ☐ 2 blocks (1/4 mile) ☐ More than 1/4 mile

Please answer the following questions about the applicant's abilities. <u>Without</u> the help of someone else, can he/she….

7. Climb three 12-inch steps if there is a handrail?
   ☐ Always ☐ Sometimes ☐ Never
8. Wait outside for 10 minutes?
   ☐ Always ☐ Sometimes ☐ Never
9. Give addresses and telephone numbers upon request?
   ☐ Always ☐ Sometimes ☐ Never
10. Ask for, understand, and follow directions?
    ☐ Always ☐ Sometimes ☐ Never
11. Deal with unexpected situations or unexpected change in routine?
    ☐ Always ☐ Sometimes ☐ Never
12. Get from the bus to the door of their destination?
    ☐ Always ☐ Sometimes ☐ Never

How does the applicant's disability prevent him/her from using fixed route service? Please explain completely:

_____

_____

_____

_____

Does the applicant's condition/disability change from day-to-day, or season-to-season in ways that affect their ability to use the fixed route service?

No _____ Yes _____

If yes, please explain:

_____

_____

Professional's Name: _____

Professional's Title: _____

Office Address: _____

Office Phone Number: _____

Professional's Signature: _____