ADA Paratransit Certification Application

Citilink Access Service is a shared ride, public paratransit service for people with disabilities who are unable to use regular accessible Citilink fixed route service for some or all of their public transportation needs due to their disability. The Americans with Disabilities Act (ADA) outlines specific criteria to determine eligibility for paratransit service.

The existence of a disability does not, by itself, qualify you for paratransit service. Eligibility is based solely on your functional ability to use the fixed route bus. If the effects of your disability prevent you from getting to or from a bus stop, waiting for a bus, getting on or off a bus, or navigating the bus system, you may be eligible for some level of paratransit service. Eligibility determinations are based upon the limitations caused by your disability. You may qualify for partial or full service.

After you submit your completed application, we may request you to participate in an in-person interview and/or functional assessment. Your application will not be considered complete until all requested information is provided to us. Once we have received all necessary information, an eligibility determination will be made within 21 days. You will be notified by mail of the decision.

If you feel that, due to the effects of your disability, you are unable to successfully travel using the regular, fixed route bus, some or all of the time, please complete the application form.

- Complete pages 1-5 of the application form (please print clearly).
- Ensure the applicant, parent or legal guardian, or power of attorney signs the application on page 5. A signature is required before an application will be processed.
- Ensure page 6 is completed and signed by an approved provider (see list of approved providers on page 5).
- Everything must be completed, signed, and legible or the application will be returned.
- Please return all pages of the application together. Any incomplete application will be returned.

Please mail the completed and signed application as well as any supporting paperwork, to:

Citilink Paratransit Services
801 Leesburg Rd
Fort Wayne, IN 46808

The information obtained in this certification process will only be used by the Fort Wayne Transportation Corporation 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.

New Application _____ Recertification _____

PART 1: Applicant Information (*please write clearly*)

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Gender (please circle) M F

Residence Address _____ Apt/Rm/Unit #_____

Name of Facility/Apt Complex _____

City: _____State _____ Zip _____

Telephone # (Home): _____ (Work): _____

Emergency Contact: Name _____

Relationship _____ Phone Number _____

PART 2: Qualifying Disability Information (*please write clearly*)

1. List the health condition(s) or disability that would prevent your use of the fixed route bus, some or all of the time. List **only** the ones that impact your ability to use the regular bus. Please be specific.

_____
_____
_____
_____
_____
_____
_____

2. Please explain how this disability:

   Prevents you from getting to or from a regular, fixed route bus stop?

   _____
   _____

   Prevents you from waiting at a regular, fixed route bus stop?

   _____
   _____

   Prevents you from getting on or off a regular bus?

   _____
   _____

   Prevents you from being able to ride a regular, fixed route bus or to understand and follow transit instructions?

   _____
   _____

General:

- Are you on any medication that affects your functional abilities? Yes ___ No ___

  If yes, specifically, what side effect(s) are you experiencing?

  _____
  _____

Physical mobility (*if applicable*): Permanent _____ Temporary (expected duration) _____

- How far can you walk, with or without a mobility aid?

  200 feet: Yes _____ No _____ Sometimes _____
  ¼ mile: Yes _____ No _____ Sometimes _____
  ¾ mile: 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 _____

- Are you able to do the following with *or* without a mobility aid?

  Up/down a moderately steep hill Yes _____ No _____ Sometimes _____
  Uneven terrain Yes _____ No _____ Sometimes _____
  Stand for 20 minutes Yes _____ No _____ Sometimes _____
  Tolerate cold Yes _____ No _____ Sometimes _____
  Tolerate heat Yes _____ No _____ Sometimes _____

Seizures (*if applicable*): Permanent _____ Temporary (expected duration) _____

- Type and frequency of seizure? _____

Vision (*if applicable*): Permanent _____ Temporary (expected duration) _____

- What is your corrected visual acuity? R: _____ L: _____
- Have you had mobility training related to your vision impairment?
  Yes _____ No _____ Unknown _____

Cognitive (*if applicable*): Permanent _____ Temporary (expected duration) _____

- Can you give addresses and phone numbers upon request? Yes _____ No _____
- Can you recognize a destination or landmark? Yes _____ No _____
- Can you deal with unexpected situations or unexpected change in routine? Yes _____ No _____
- Can you inquire, understand, and follow directions? Yes _____ No _____
- Can you safely and effectively travel through crowded and/or complex facilities? Yes _____ No _____

Psychological (*if applicable*): Permanent _____ Temporary (expected duration) _____

- Please answer questions under Cognitive section above.
- Are there any behavorial issues that would impact your use of public transportation (which is what paratransit is)? If so, what are they?
  _____
  _____
- Are your mental health issues currently controlled by medication? Yes ____ No ____ Sometimes _____

PART 3: Mobility (*please write clearly*):

1. How have you most recently been traveling? Check all that apply

   ____ Citilink Fixed Route _____ Taxi _____ Drive
   ____ Ride in a car _____ Bicycle _____ Walk
   _____ Private transportation company _____ Other (please specify)
   _____

2. Have you ever used the regular, fixed route buses independently?

   _____ Yes, I typically use the regular buses _____ times a week.
   _____ Yes, I used to but stopped because (please be specific)
   _____
   _____ No

3. What accommodations would assist you in using the fixed route bus system?

   __ Route & schedule information __ Bus stops closer to home/destination
   __ Accessible bus stop and pathway __ Bench/shelter at bus stop
   __ No transfers __Training to use the fixed route bus
   __ Other _____

4. Because of your disability, do weather conditions (such as heat, cold, rain, snow, or ice), terrain conditions (such as hills, uneven surfaces, or curbs), or environmental conditions (such as darkness, bright lighting, or air quality) prevent you from using a regular bus independently? Yes ____ No _____

   If yes, please explain (which ones and how?) _____
   _____
   _____
   _____

5. Which of the following mobility aids or equipment do you use when you travel outside of your home? Check all that apply and indicate the percentage of time you use the aid. (Example: support cane 90%, no aids 10%)

No aids	_____%	Power scooter	_____%
White cane	_____%	Manual wheelchair	_____%
Support cane	_____%	Guide Dog	_____%
Crutches	_____%	Personal Care Attendant	_____%
Walker	_____%	Other (please specify)	_____%
Power wheelchair	_____%	_____	

6. If you use a wheelchair or scooter, is your combined weight (you and the wheelchair/scooter) more than 600lbs? _____ Yes _____ No

   If yes, what is the combined weight? _____

   If you use a manual wheelchair, how far are you able to self-propel? _____

   If you use a power wheelchair/scooter, how far are you able to travel outside on your own and what would limit your abilities?
   _____
   _____

PART 4: Application Verification

I agree the information provided on this application is true and correct to the best of my knowledge. The purpose of this application is to determine if I am eligible to use Paratransit services, or if at times I can ride the fixed route buses. I understand that falsification of information could result in loss of Paratransit services as well as a penalty under the law.

I agree to notify Citilink if my condition changes, if my mobility device has been replaced, if I have a new mobility device, or if I no longer need to use Paratransit service.

_____ Date _____
Signature of Applicant or Legal Guardian

Person completing application ***if not*** the applicant:

_____ _____
Printed Name Relationship to Applicant

_____ _____
Signature Date

_____
Contact Phone #

This concludes the applicant's portion of the application. The following pages MUST be completed by a licensed Medical or Mental Health provider who is most familiar with you and your disability/limiting condition.

Approved providers are limited to the following professions. Please check the appropriate box for your approved provider.

___ Medical Doctor (MD or DO)
___ Physician Assistant or ARNP
___ Ophthalmologist or Optometrist
___ Certified Orientation & Mobility Specialist
___ Psychologist (Ph.D.)
___ Mental Health Clinician III or IV
___ Audiologist (certified by ASHA)
___ LICSW (employed at medical facility)

PART 5: Professional Verification

Applicant Name _____

Thank you for completing this application. We will use this information to help determine paratransit eligibility in accordance with the Americans with Disabilities Act (ADA). Paratransit is a tax-supported service for individuals who, because of the effects of their disabilities/limit conditions, are not able to ride the regular ramp-equipped and accessible bus. **Age, language, convenience of the service, fear of falling, inability to drive, and inability to carry packages are NOT qualifying factors for paratransit service.** Please call 260-432-4977 if you have any questions.

Please review the information provided by the applicant on this application form. Based on your knowledge of the applicant's condition, is the information accurate?
_____ Yes _____ No _____ Somewhat

If you checked *No* or *Somewhat*, please explain _____
_____
_____
_____

Are there any changes or additions you would make to the list of stated Diagnosis/Disability shown on page 1, Part 2 of this application? _____
_____
_____
_____

Provide any additional information that you deem relevant as to why the effects of the applicant's disability/limiting condition will prevent their use of the regular, fixed route bus system.
_____
_____
_____
_____

I am an approved provider (see page 6), licensed in the State of Indiana in the field indicated below, and certify that the above-mentioned individual has the disability and limitations indicated above.

_____ _____
Professional Care Provider's Signature Date

_____ _____
Professional Care Provider's Name (please print) Phone #

_____ _____
Mailing Address Clinic Name

_____
Individual National Provider Identifier (NPI) or IN DOH License number
*This form is considered incomplete without valid individual number.