



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.

1. New Application \_\_\_\_\_ Recertification \_\_\_\_\_
2. Name: \_\_\_\_\_
3. Address: \_\_\_\_\_ Apt/Rm # \_\_\_\_\_  
Name of Facility/Apt Bldg: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
3. Telephone # (Home): \_\_\_\_\_ (Work): \_\_\_\_\_
4. Date of Birth: \_\_\_\_\_ Male/Female: \_\_\_\_\_
5. Emergency Contact: \_\_\_\_\_  
Phone Number: \_\_\_\_\_
6. What is the disability that prevents you from using the fixed route service?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Is this condition temporary? \_\_\_\_\_ If yes, expected duration \_\_\_\_\_
7. How does this disability prevent you from using fixed route services?  
Please explain in detail. Use an additional sheet if necessary.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. Are there any other effects of your disability of which we need to be aware?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



### ADA Paratransit Certification Application

THE FOLLOWING INFORMATION WILL BE USED TO ENSURE THAT AN APPROPRIATE VEHICLE IS UTILIZED TO PROVIDE YOUR TRANSPORTATION AND THAT AN ACCURATE ANALYSIS OF YOUR TRIP REQUESTS CAN BE MADE BY CITILINK.

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

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

If you use a wheelchair/scooter, is the combined weight of you and your mobility device more than 600 pounds? Yes \_\_\_\_\_ No \_\_\_\_\_

Can you travel 200 feet without the assistance of another person?

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

Can you travel 1/4 mile without the assistance of another person?

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

Can you travel 3/4 mile 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 \_\_\_\_\_

**I hereby certify that the above information is correct.**

**Signed:** \_\_\_\_\_

**Date:** \_\_\_\_\_



## ADA Paratransit Certification Application

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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 Code: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_



**ADA Paratransit Certification Application**



**◆ Authorization for Release of Information ◆**

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In order to allow Citilink 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.

Please check one of the following:

Physician \_\_\_\_\_

Health Care Professional \_\_\_\_\_

Rehabilitation Professional \_\_\_\_\_

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The above is familiar with my disability and is authorized to provide the necessary information to Citilink for completion of certification.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_

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Please Print Name of Applicant: \_\_\_\_\_

Applicant's Date of Birth: \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_





**ADA Paratransit Certification Application**

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 \_\_\_

Inquire, understand and follow directions? Yes \_\_\_ No \_\_\_

Safely and effectively travel through crowded and/or complex facilities? Yes \_\_\_ No \_\_\_

Describe any other effect of the disability of which Citilink should be aware:



Name: \_\_\_\_\_

Business Address: \_\_\_\_\_

Business Phone Number: \_\_\_\_\_

Signature: \_\_\_\_\_

Mail to: Paratransit Services  
Citilink  
801 Leesburg Rd  
Fort Wayne, IN 46808