



***Providing Courteous and Responsive  
Transportation***

**PARATRANSIT SERVICE AND  
ADA ELIGIBILITY APPLICATION  
AND INFORMATION**



*"Inspiring a Vibrant Community"*

## ADA PARATRANSIT APPLICATION FORM

Please complete this application to the best of your ability and be as thorough as possible. If you have difficulty answering any questions on the application, or if you need assistance completing this form, please call Debbie Jones or Bruce Morrow at (928) 634-2287. **In order for the application to be considered complete, every question on the application must be answered. We cannot begin processing the application until it is complete.** If a question does not apply to you, please write 'Not Applicable' or 'NA'.

The purpose of this application is to provide an opportunity for you to describe how your disability prevents you from riding the fixed-route system. This includes any environmental and/or physical barriers that prevent you from riding the fixed-route buses. The more complete and accurate the information you provide is, the better CAT will understand your abilities and travel challenges. Information contained in this application will be kept confidential and will only be shared with the professionals involved in the evaluation of your eligibility for CAT, or others if disclosure is required by law.

There are 2 sections to this application. Part 1 is to be filled out by the applicant or by someone on the applicant's behalf. Part 2 is to be filled out by a professional familiar with the applicant's functional abilities. The application will not be accepted or considered complete until both parts are completed in full and submitted to CAT.

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### Part 1

**Please Print:**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Apt \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Email Address \_\_\_\_\_

**To be completed by any person assisting the applicant with the completion of this application:**

Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_  
Address \_\_\_\_\_  
Relationship to Applicant \_\_\_\_\_  
Email Address \_\_\_\_\_

Please provide us with the name of the person you would like us to contact in case of an emergency. Select someone who will not be riding with you.

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

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

Work Phone \_\_\_\_\_

Email Address \_\_\_\_\_

**To whom should we send correspondence (information regarding eligibility, late trips, missed trips, etc.)? Information may only be sent to one person.**

- Self
- Case Manager
- Other

**If we need to send correspondence to a Case Manager or other, please fill out the following information:**

Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Address \_\_\_\_\_

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

**Will you need future materials in an alternative format? If yes, please circle one:**

Braille                      Large Print                      Email                      Disc

What is the disability that prevents you from using the fixed-route system?

\_\_\_\_\_

Is your disability considered permanent?      Yes      No

If no, how long do you expect to have this disability? \_\_\_\_\_

Does your disability change from day to day?      Yes      No

If yes, please explain:

\_\_\_\_\_



**Please read the following statements and check those which best describe what you believe is your ability to use the transit fixed- route system. You may select more than one.**

- I can use the fixed-route bus sometimes, if the conditions are right.
- I have difficulty understanding and/or remembering all of the things I need to do to find my way to and from the bus.
- I have a temporary disability which prevents me from getting to the bus stop. I will need only until I recover.
- I believe I could learn to ride the fixed-route bus, if someone would teach me.
- I have difficulty or cannot climb stairs and can only board a bus with a lift/ramp.
- I have a visual disability which prevents me from getting to and from the bus.
- The severity of my disability changes from day to day. I can ride the fixed-route bus only when I am feeling well.
- I have a severe medical condition. My condition results in an impairment which makes it impossible for me to use the fixed-route system.
- I have never attempted to ride the fixed-route buses.
- I am not sure if I can ride the fixed-route buses.

Have you ever received training to learn how to use the fixed-route bus or to travel around the community?    Yes    No

- a. If yes, by which agency were you trained? \_\_\_\_\_
- b. Did you successfully complete training?    Yes    No
- c. If you did not complete training, would you like to participate in training to learn to ride the fixed-route bus?    Yes    No

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 use Paratransit services and that I may be required to do an in-person interview if additional information is needed to determine my eligibility.

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Applicant's Signature or Mark

Date



## **PART 2 Professional Verification**

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Please take this section of the application to a professional for verification of your disability and your functional abilities. We prefer that this section be filled out by someone who is not only familiar with your diagnosis, but who is also familiar with your mobility. We suggest taking these forms to an In Home Care Provider, Case Manager, Social Worker, Health Care Professional (Nurse, Physical Therapist, Rehabilitation Specialist, etc.), or Physician. If you have any questions regarding what professionals will be accepted or if the professional you have chosen is charging you a fee for the completion of this paperwork, please call the CAT Office and speak with Debbie Jones or Bruce Morrow (928) 634-2287.

### **GUIDELINES FOR PROFESSIONAL VERIFICATION**

Your patient/client has requested eligibility for CAT Paratransit transportation service. Because of your professional relationship with this applicant, you are uniquely qualified to help clarify his or her **functional abilities and limitations**. The following are guidelines for using Paratransit. These guidelines may help you in understanding the types of information we need in order to determine the applicant's eligibility for Paratransit.

The basis for CAT ADA eligibility is the American with Disabilities Act. Eligibility is based 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 Eligibility.
- Whether the individual is **prevented** 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. Eligibility is unique to the individual's personal functional ability and reflects the patient's ability to use the bus and under what circumstances (ex: could use the bus if it were not more than two level blocks to the bus stop, and there was no snow or ice present).

### **FOR MORE INFORMATION**

If you have any questions regarding ADA Paratransit Eligibility or these forms contact either Debbie Jones or Bruce Morrow at CAT (928) 634-2287. Thank you for your cooperation.

**PROFESSIONAL VERIFICATION**

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

1) In what capacity do you know this individual? \_\_\_\_\_  
\_\_\_\_\_

2) How long have you known this individual? \_\_\_\_\_

3) What is the last date of face-to-face contact (by you or your agency) with this individual?  
\_\_\_\_\_

4) Primary Disability/Medical Condition \_\_\_\_\_

5) Secondary Medical Condition(s) \_\_\_\_\_  
\_\_\_\_\_

6) Date of onset \_\_\_\_\_

7) Currently receiving any treatment? \_\_\_\_\_  
\_\_\_\_\_

8) What is the prognosis? \_\_\_\_\_

9) Are the effects of the disability variable? \_\_\_\_\_ Yes \_\_\_\_\_ No

10) Medication side effects reported by patient/client: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11) Are any of the following affected by the individual's disability? (check all that apply)

- |   |                                     |
|---|-------------------------------------|
| _____ Disorientation                        | _____ Monitoring time               |
| _____ Problem solving                       | _____ Judgment                      |
| _____ Short-term memory                     | _____ Communication                 |
| _____ Long-term memory                      | _____ Inconsistent performance      |
| _____ Gait or balance                       | _____ Inappropriate social behavior |
| _____ Other (please explain) _____<br>_____ |                                     |

12) How will using Paratransit better suit this individual than using the fixed-route system?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

