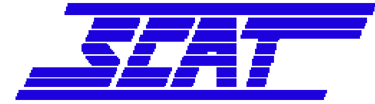

Springfield City Area Transit

U.S. Architectural and Transportation Barriers Compliance Board Americans with Disabilities Act

The Americans with Disabilities Act (ADA) prohibits the discrimination on the basis of disability in State and Local government services and transportation (title II) …

Accessibility Requirements

The ADA requires that the Architectural and Transportation Barriers Compliance Board (Access Board) issue guidelines to ensure that buildings, facilities, and vehicles covered by the law are accessible, in terms of architecture and design, transportation, and communication, to individuals with disabilities. Regulations issued by the Department of Justice and the Department of Transportation must be consistent with the Access Board's guidelines. The Access Board issued the Americans with Disabilities Act Accessibility Guidelines (ADAAG) for buildings and facilities on July 26,1991; and amended it on September 6, 1991 to include additional requirements for transportation facilities. The Access Board also issued ADAAG for transportation vehicles on construction and alterations of places of public accommodation and commercial facilities covered by title III of the ADA. The Department of Transportation has adopted ADAAG as the accessibility standard for new construction and alterations of private entities covered by titles II and III of the ADA. ADAAG is reprinted in the Department of Justice and Department of Transportation regulations, as applicable.

DOT final rules on transportation are in 49 CFR Parts 37 and 38 (56 FR 45584, September 6, 1991). DOT final rules require public entities to use ADAAG as accessibility standards for new construction and alterations of transit facilities and for transit vehicles, 49 CFR 37.7 and 37.9. Included in these regulations was a requirement that public entities operating fixed-route transportation service for the general public also provide complimentary service to persons unable to use fixed-route systems.

Therefore, the Springfield City Area Transit system, operated by the Springfield Bus Company offers Complimentary Paratransit Service to accommodate these regulations. Attached is an application that each individual applying for service must complete. Certification will be granted based on the criteria defined in the "Americans with Disability Act of 1990."

If an individual has a disability that is not visible, verification may be requested from a physician, healthcare provider, social service agency, etc.

Should individuals have questions about the application or any part of the ADA Paratransit Service offered through SCAT, should call 937-328-3597 and ask for the Operations Manager.

Thank you for your interest in the SCAT ADA Paratransit Transportation Service.

NOTE: Returning this application via U.S. Postal Service will cost you $ .60 in postage due to the weight.

Springfield City Area Transit (SCAT)
Operated by the Springfield Bus Company
100 Jefferson • PO Box 1265
Springfield, O 45501
937.328.7228 Office • 937.328.3596 Fax • scatopsmgr@siscom.net Email

TODAY'S DATE: ______________________

REQUEST FOR CERTIFICATION OF ADA PARATRANSIT ELIGIBILTY

Please note that the information obtained in this certification process will only be used for the provision of obtaining ADA Complementary transportation services. (Please type or print clearly)

NAME: ____

ADDRESS: ____

CITY: ______________________STATE _____ZIP _________DOB ______/______/______

TELEPHONE NUMBER: [HOME] ( ) _________________ [WORK] ( ) __________________

I. What is the disability that prevents you from using fixed-route bus service?

____

____

Is this condition temporary? _____Yes _____No

If yes, please list the date you expect the temporary condition to no longer exist:

____

Is this condition seasonal? _____Yes _____No

If yes, do you have either medically defined and diagnosed temperature sensitivity or a temperature regulation disorder, which could preclude you from waiting on a fixed-route bus?

_______Yes _____No _____Sometimes

Range of sensitivity: ____

II. Do you have a communication disability, which necessitates the use of some type of communication aid? _______Yes ______No _____Sometimes

What kind of communication aid do you require?

____

____

____

III. Does your disability allow you to:

Give addresses and telephone numbers upon request?

_______Yes _____No _____Sometimes

Recognize a destination or landmark (i.e., Gas station, movie theatre, etc.)?

_______Yes _____No _____Sometimes

Deal with unexpected situations or changes in routine?
______Yes ______No ______Sometimes

Ask for, understand and follow directions?
______Yes ______No ______Sometimes

Make arrangements-keep appointments?
______Yes ______No ______Sometimes

IV. If you require the use of mobility aids. Please check all which apply:

_____ Manual Wheelchair ______ Electric Wheelchair

_____ Electric Scooter ______ Case or Care Worker

_____ Cane ______ Walker

_____ Service Animal (i.e., dog) ______ Oxygen

Other: ____

If you use a manual wheelchair, what type of obstacles could prevent you from using a fixed-route bus equipped with a lift or ramp?

____

V. How far can you travel without the assistance of another person?

____ Less than 200 feet? _____ Up to ¼ mile? _______________Other

VI. Can you climb three 12-inch steps without assistance?
_____Yes ______No ______Sometimes

VII. Can you wait outside without support for more than 10 minutes?

_____Yes ______No ______Sometimes

VIII. Is there anything else you can tell us about your disability that would prevent you from using out fixed-route bus service? Please explain completely. Use the back of this page or additional sheets if necessary.

IX. Is there any additional information about your disability that we would need to be aware of?

____

____

____

REQUEST FOR CERTIFICATION OF ADA PARATRANSIT ELIGIBILTY

RELEASE OF INFORMATION/CONSENT FORM

In order to allow the ADA Program Manager to evaluate your request, it may be necessary to contact your physician or some other healthcare professional that is familiar with your disability to confirm the information you have provided. Please complete the following questions and authorization form.

Please provide proof this form has been completed by a Physician or Healthcare Professional (i.e., stamp, etc.)

______Physician ______Healthcare Professional ______Rehabilitation Professional

Other____
After checking above, please list your name, title, occupation, address, phone & signature

_________________________ ________________ ________________________________
Name Title Occupation

____
Address City, State, Zip Code

X ____
Signature of Physician or Healthcare Professional

____
Address City, State, Zip Code

I authorize the professional(s) named above to release any information necessary to the ADA Program Manager Upon request.

Applicant's Signature: ______________________________________Date: ____________

Witness (Other than ADA Program Manager): ____________________________________

If someone other than the applicant requesting certification has completed this application in whole or in part, that person must complete the following. <u>A COPY OF THE POWER OF ATTORNEY FORM MUST ALSO ACCOMPANY THIS PACKET.</u>

NAME:
____
ADDRESS:
____

CITY: _____________________STATE: ______ZIP: ______DOB: ______/______/______

TELEPHONE NUMBER [Home] (   ) _____________ [Work](   ) ___________________

RELATIONSHIP: ____

SIGNATURE: _________________________________DATE: _________________________

REQUEST FOR CERTIFICATION OF ADA PARATRANSIT ELIGIBILTY

RIDER SURVEY

This form WILL NOT be used in determining the individuals certification.

The following information will be used by the Operations Manager/ADA Program Manager to help him/her to get a better picture of the needs that may be required of the transit system

Your response will be used solely for planning purposes and in will no way be used to limit or control the type or service provided to you.

1. How many times do you estimate that you will use this service each month?

______ 1-5 times

______ 6-10 times

______ 11-15 times

______More than 16 times

2. Trips to be taken will be to:

______A Physician

______A healthcare professional

______A Human Service Agency

______To go Shopping

_______For a Social Gathering

______To Visit Friends

______Other (please specify): ____

3. If this service were not available-would you be able to make your appointments?

_____Yes _____No _____Sometimes

4. What other type of transportation could you use if this service was unavailable?

______ A family member would take me

______ A friend

______ A taxicab

______ Walk

______ Other (please specify): ____

REQUEST FOR CERTIFICATION OF ADA PARATRANSIT ELIGIBILTY

I, _________________________________ have read, or had read to me the entire application process material. I understand the consent and all questions asked. I further understand that if I am not approved for certification that I may file a written appeal to the Paratransit Appeals Board*, within sixty –(60) days after the ADA Program Manager has issued a written notice of denial.

Applicants Signature: _______________________________ Date: _______________

Witness: ____ Date: _______________

ADA Program Manager: ______________________________ Date: _______________

____Copy forwarded to Applicant on____/____/____

____Original Retained

*If service is denied, an appeal may be made in writing to the Paratransit Appeal Board at:

Paratransit Appeal Board
Transportation Coordinator
City of Springfield
76 East High Street
Springfield, OH 45502
(937) 324-7311

REQUEST FOR CERTIFICATION OF ADA PARATRANSIT ELIGIBILTY

Please identify a relative or close friend who we may contact in the event of an emergency. (Please print clearly and complete all information asked)

NAME: ____

ADDRESS: ____

CITY: ______________________________ STATE _____ ZIP: ____________DOB: ____/____/____

TELEPHONE NUMBER: (HOME) ( )____________________(WORK) ( )_____________________

RELATIONSHIP____

- -

(TO BE USED FOR CERTIFICATION PURPOSES ONLY)

I hereby certify that the individual's name which appears on this REQUEST FOR CERTIFICATION OF ADA PARATRANSIT ELIGIBILTY form

Has__________/has Not ______________been approved.

Month/Year for Annual Re-Certification: ________/________

Month/Year for Temporary Re-Certification: ________/________

____ ________________________

ADA Program Manager's Signature Date