

The Americans with Disabilities Act of 1990

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.

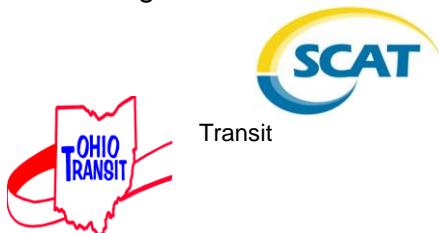
Therefore, the Springfield City Area Transit system, operated by First Transit offers Complimentary Paratransit Service to accommodate these regulations. Attached is an application that each individual applying for service must complete. Certification will be granted based on the criteria defined in 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 speak with the staff.

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 First Transit

Springfield City Area

P.O. Box 2239

100 Jefferson Street Springfield, Ohio 45501-2239

937-328-7228

PARATRANSIT ELIGIBILITY APPLICATION

SCAT Paratransit provides services to individuals who cannot use the regular SCAT fixed route bus system to make all of their trips. To be eligible for this service, the functional limitations of an individual's disability must **prevent** use of regular buses. Age, distance from bus stop, being in a wheelchair, a medical diagnosis, or being classified as having a "disability" by themselves are not taken into consideration in making an eligibility determination.

Part 1 must be filled out with the applicant's answers. The applicant can receive assistance from another person but wherever possible the applicant's answers must be written. If another person assists please state their relationship at the end of Part 1 and have the applicant sign. **Part 2 must be filled out by your healthcare professional** verifying your answers to be true according to your medical records and giving permission to release any information needed to make our determination.

PART 1 TO BE COMPLETED BY APPLICANT

PLEASE TYPE OR PRINT CLEARLY IN INK

Please Check One: New Applicant Recertification

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Work #: _____ DOB: _____

E-mail Address: _____

Please check all the following media you currently use:

Large Print Auto Cassette Braille Electronic (E-mail)

1. What type of condition(s) prevents you from using SCAT's fixed-route bus system? (Check all that apply)

- None Physical Visual Deaf/Blind
Brain Injury Speech Hearing Mental Health Condition
Mental Retardation/Developmentally Delayed
Other (current diagnosis):_____

2. How does this condition(s) prevent you from using the regular SCAT fixed-route bus system? (**please give detailed examples**):_____

3. Is this condition temporary? YES NO

If yes, what is the expected duration?_____ Months

4. Do you currently use SCAT's fixed-route bus system?

- YES SOMETIMES NO

If yes or sometimes what bus routes do you use?_____

5. Is there a bus stop near your home? YES NO

What is the location (i.e. the corner of Main St. and Plum St.)?_____

6. Are you able to get on and off a SCAT's fixed-route buses equipped with a wheelchair lift, without assistance? (The driver will operate the wheelchair lift and secure the wheelchair/scooter.)

- YES SOMETIMES NO

If you cannot please explain:_____

7. Are you able to get to the bus stop nearest your home? (i.e. walk, use wheelchair/scooter)

- YES SOMETIMES NO

If you cannot please indicate all of the following reasons:

- | | |
|---|---|
| <input type="checkbox"/> Cannot negotiate hilly or rough terrain | <input type="checkbox"/> Cannot travel on surfaces covered with ice or snow |
| <input type="checkbox"/> Cannot tolerate extreme weather temperatures | <input type="checkbox"/> Cannot cross busy intersections |
| <input type="checkbox"/> Lack of sidewalks and or no curb cuts in my neighborhood | <input type="checkbox"/> Cannot identify correct bus during daylight |
| <input type="checkbox"/> Cannot locate bus stops due to Visual condition | <input type="checkbox"/> Poor condition of sidewalks (i.e. uneven/crumbled) |
| <input type="checkbox"/> Cannot wait outside for ten minutes | <input type="checkbox"/> Other (please be specific): _____ |
-

8. Once you get off of the bus, are you able to get where you are going?

- YES SOMETIMES NO

When you cannot please indicate the following reasons:

- | | |
|---|---|
| <input type="checkbox"/> Cannot negotiate hilly or rough terrain | <input type="checkbox"/> Cannot travel on surfaces covered with ice or snow |
| <input type="checkbox"/> Cannot tolerate extreme weather temperatures | <input type="checkbox"/> Cannot cross busy intersections |
| <input type="checkbox"/> Lack of sidewalks and/or no curb cuts | <input type="checkbox"/> Cannot locate destination due to visual impairment |
| <input type="checkbox"/> Other (please be specific): _____ | |
-

9. Are you able to do the following functions independently?

	YES	SOMETIMES	NO
Find your way between familiar locations?			
Grasp coins, passes and handles?			
Communicate address, destinations, and telephone numbers on request?			
Ask for, understand, and follow directions?			
Deal with unexpected situations or unexpected changes in routine?			
Able to go up and down steps?			
Recognize a destination or landmark?			
Walk or use a wheelchair/scooter 200 feet?(City block)			
Walk or use a wheelchair and travel ¼ mile (1,300 feet/just under 4 ½ football fields)?			

10. If you use an aid, check those that apply:

- Manual wheelchair
- Electric wheelchair
- 3-wheel scooter
- Crutches
- Walker
- Service animal
- Portable oxygen
- Walking cane
- Cane used by the visually impaired

If you use a manual or powered wheelchair or scooter, is it more than 30 inches wide, more than 48 inches long, or does it, when in use, weigh more than 600 pounds? YES NO

11. Do you need a person to assist you when you are traveling?

YES NO

If you travel with another person that assists you, does this person assist you in:

- Getting to or from bus stops Getting on or off the bus
 Getting you where you are going Assist you once you get to the destination
 Other (please explain): _____
-

TRAVEL TRAINING

Travel training is available and free for those who are eligible to ride Paratransit and would like to use the regular SCAT bus as well. Programs can be tailored to help you learn how to use specific routes for specific trips. Upon completion of the training SCAT bus service can be accessed at a reduced fare.

PART 2 TO BE COMPLETED BY HEALTHCARE PROFESSIONAL

REQUEST FOR CERTIFICATION OF ADA PARATRANSIT ELIGIBILITY 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
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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. A COPY OF THE POWER OF ATTORNEY FORM MUST ALSO ACCOMPANY THIS PACKET.

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ DOB: ____/____/____

TELEPHONE NUMBER [Home] () _____ [Work]() _____

RELATIONSHIP: _____

SIGNATURE: _____ DATE: _____

REQUEST FOR CERTIFICATION OF ADA PARATRANSIT ELIGIBILITY

RIDER SURVEY

This form WILL NOT be used in determining the individual's certification.

The following information will be used by the First Transit staff 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 ELIGIBILITY

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 ELIGIBILITY

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 ELIGIBILITY form

Has _____/has Not _____ been approved.

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

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

ADA Program Manager's Signature

Date