



900 10th Street, Coralville, IA 52241
(319) 248-1790

ADA PARATRANSIT ELIGIBILITY APPLICATION AND INSTRUCTIONS

Dear Customer:

Thank you for inquiring about eligibility for “ADA Paratransit” service. Enclosed is a copy of an ADA Paratransit Application Form. **Please read this and the enclosed material carefully before completing the application.**

The Americans with Disabilities Act of 1990 (ADA) requires Coralville Transit to provide equivalent public transportation to individuals with disabilities that cannot board, ride or get to an accessible fixed-route bus due to their disability. This service must be comparable to the service that is provided to individuals without disabilities. The law is very specific as to whom and under what circumstances eligibility may be granted to use Paratransit transportation. Paratransit eligibility is not automatically assumed because of a disability.

You or your designee must completely answer all questions. A detailed explanation of how your disability makes it functionally challenging for you to use an accessible bus is required and you must certify that information is complete and correct by signing and dating. You will also find a Medical/Professional Verification form to be completed by your physician or medical agency. **Please complete your application as thoroughly as possible.** The questions will assist us in determining the specific limitation you have in using our service.

It will be necessary for a licensed medical professional (not a relative or friend) that sees you on a professional basis to complete the medical verification portion of your application. This person may be a registered nurse, social worker, physician, physical therapist, psychologist, occupational therapist, chiropractor, speech pathologist, physician’s assistant, nurse practitioner, or mental health counselor employed by a medical facility. **Contact our office if assistance is needed in completing your application.**

BOTH THE CLIENT AND MEDICAL PROFESSIONAL VERIFICATION FORM MUST BE COMPLETED AND SUBMITTED TOGETHER. IF ANY SECTIONS ARE LEFT BLANK THE APPLICATION WILL BE RETURNED TO YOU AS INCOMPLETE AND IT WILL DELAY THE CERTIFICATION PROCESS.

The information you provide in this application is confidential.

All applicants, whether new or persons applying for recertification, must complete a new application. The ADA certification process may involve an in-person interview and/or functional assessment to determine your abilities to use Coralville Transit’s fixed-route service.

Applications should be returned to: Coralville Transit
Attn: Vicky Robrock
900 10th Street
Coralville, IA 52241

If you are determined eligible for Coralville’s ADA Paratransit service, your eligibility will be for one of the following types:

1. CONDITIONAL ELIGIBILITY:

You are able to use the fixed route buses for **SOME** of your trips, and qualify for ADA Paratransit Service for other trips.

2. UNCONDITIONAL ELIGIBILITY:

Your disability or health condition always prevents you from using the fixed route buses and you qualify for ADA Paratransit for **ALL** of your trips.

3. TEMPORARY ELIGIBILITY:

You have a health condition or disability that **TEMPORARILY** prevents you from using the fixed route buses and you qualify for ADA Paratransit for a specified period of time.

A determination is made based upon an individual’s ability to board, ride and disembark independently from a fully accessible fixed-route vehicle. The terrain and architectural structure are also considered. It is important for all applicants to realize that this is a transportation decision, not a medical authorization.

Lack of Coralville Transit fixed-route service in an area or at specific schedule times does not qualify as adequate justification for ADA Paratransit eligibility. Coralville’s ADA Paratransit service provides service within the incorporated city limits, or three-quarters of a mile outside of Coralville Transit’s bus routes during the same hours as fixed-route bus service for those determined eligible.

A determination of eligibility will be made by Coralville Transit within 21 days of receipt of the completed application. If an application is not processed within 21 days, presumptive eligibility will be granted on the 22nd day until and unless the application is denied in writing. Coralville Transit will notify you in writing of the decision about your eligibility for ADA paratransit service. If it is determined that you are able to use the fixed route system and are not eligible for paratransit service, Coralville Transit will explain the reason for this determination. If you are determined **Not Eligible** for Coralville’s ADA Paratransit service, and/or are dissatisfied with your eligibility type you may appeal the decision. A written appeal to the **MPOJC (Metropolitan Planning Organization of Johnson County)** must be received within 60 calendar days of the denial letter. Simply submit a letter stating you wish to appeal the decision that was made and why you feel you should be eligible for ADA Paratransit service. Attach copies of any other pertinent information. The decision is the final determination. You may only re-submit an application if your condition worsens. ADA Paratransit service will not be provided during the appeal process. However, if the appeal process takes longer than 30 days, service will be granted until the appeal process is completed.

Appeals must be in writing and forwarded to:

MPOJC
Attn: ADA Paratransit Appeal
410 E. Washington
Iowa City, IA 52240

APPLICATION FOR ADA PARA-TRANSIT SERVICES

It is important to complete all parts of the attached form. Applications that are not fully completed or clearly written will be returned, which will delay the eligibility process. Please print.

Name: _____
 First Middle Last

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Physical address (if different from mailing): _____

City: _____ State: _____ Zip Code: _____

Daytime Phone: (____) _____ TDD/TYY: (____) _____

Evening Phone: (____) _____

Birth Date: ____/____/____
 MM DD YY

If this application has been completed by someone other than the applicant requesting certification, that person must complete the following:

Name _____

Address: _____

Relationship: _____ Phone: (____) _____

Please indicate if this person should be contacted directly if additional information is requested.

Yes _____ No _____

Emergency Contact Person(s):

Name: _____	Day Phone: (____) _____
(Primary Contact)	
Relationship: _____	Evening Phone: (____) _____

Name: _____	Day Phone: (____) _____
(Secondary Contact)	
Relationship: _____	Evening Phone: (____) _____

About Your Disability

1. What type or types of disabilities prevent you from using standard bus service (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> physical disability | <input type="checkbox"/> visual impairment |
| <input type="checkbox"/> developmental disability | <input type="checkbox"/> mental illness |
| <input type="checkbox"/> other _____ | <input type="checkbox"/> none |

2. Is your disability: Permanent or Temporary
 If temporary; what is the expected duration:
 ____/____/____ Date

3. Which of the following mobility aides do you use while travelling? (Please check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> cane | <input type="checkbox"/> extra-large wheelchair | <input type="checkbox"/> prosthesis |
| <input type="checkbox"/> long white cane | <input type="checkbox"/> power wheelchair | <input type="checkbox"/> communication board |
| <input type="checkbox"/> portable oxygen | <input type="checkbox"/> manual wheelchair | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> walker | <input type="checkbox"/> power scooter/cart | <input type="checkbox"/> none |
| <input type="checkbox"/> crutches | <input type="checkbox"/> service animal | |

4. Do you use a manual or power wheelchair or scooter? Yes No

Width(inches)	Length(inches)	Weight(passenger + mobility device)
_____	_____	_____

- | | Yes | No | Sometimes |
|--|--------------------------|--------------------------|--------------------------|
| 5. Are you able to wait 15 minutes at a public stop with your mobility device? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Can you transfer from your wheelchair to a seat in a vehicle? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you sensitive to heat? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you sensitive to cold? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do other weather/lighting conditions affect your disability? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Is your breathing affected by weather or environmental conditions? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Does your disability change after medical treatment/medications? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

12. If you answered **No** or **Sometimes** to questions 5 – 11, please explain below or attach additional paper if necessary:

13. Under the best of conditions what is the farthest you can walk (or travel using your mobility aid) without the help of another person?

- | | |
|--|---|
| <input type="checkbox"/> Less than 1 block | <input type="checkbox"/> 6 blocks |
| <input type="checkbox"/> 1 block | <input type="checkbox"/> More than 6 blocks |
| <input type="checkbox"/> 2 blocks (1/4 mile) | <input type="checkbox"/> I cannot travel outdoors alone |
| <input type="checkbox"/> 4 blocks (1/2 mile) | |

	Yes	No	Sometimes
14. Are you able to recognize printed information?	[]	[]	[]
15. Are you able to cross streets by yourself?	[]	[]	[]
16. Are you able to travel or get around by yourself after dark?	[]	[]	[]
17. Are you able to travel by yourself along sidewalks and other pedestrian ways?	[]	[]	[]
18. Are you capable and comfortable getting around in a store or shopping mall by yourself?	[]	[]	[]
19. Are you able to detect curbs and other drop offs?	[]	[]	[]
20. Are you able to travel to and from your neighborhood bus stop independently?	[]	[]	[]
21. Are you able to wait outside without assistance or support for fifteen (15) minutes?	[]	[]	[]
22. Are there barriers that prevent you from getting to and from the bus stop?	[]	[]	[]
23. Are you able to leave and return to your regular destinations (local bus stops) independently?	[]	[]	[]
24. Are you able to travel on flat surfaces in good weather?	[]	[]	[]
25. Are you able to travel on slight inclines in good weather?	[]	[]	[]

- | | Yes | No | Sometimes |
|---|-----|-----|-----------|
| 26. Could you wait if there were a seat or bus shelter? | [] | [] | [] |
| 27. Could you wait if there was not a seat or bus shelter? | [] | [] | [] |
| 28. Could you pay the fare by putting coins or tickets in the fare box, or by showing a pass to the bus driver? | [] | [] | [] |
| 29. Are you able to independently call and make or cancel trip reservations? | [] | [] | |
| 30. Can you wait alone at your residence and places to which you travel? | [] | [] | |
| 31. Could you independently ride in a taxi if one were provided? | [] | [] | |
| 32. Can you provide addresses and telephone numbers upon request? | [] | [] | [] |
| 33. Are you able to ask for, understand and follow directions? | [] | [] | [] |
| 34. Are you able to adapt to unexpected changes in routine? | [] | [] | [] |

35. If you answered **No** or **Sometimes** to questions 14 - 34, please explain or attach additional paper if necessary:

36. Do you require the services of a Personal Care Attendant (PCA) when you travel? (This person is not a companion or escort, but someone who will be helping you with mobility assistance, personal care, communication, transportation, sign language interpretation, providing services as a reader, etc., as you make your trip). [] Yes [] No

Please give Personal Care Attendant name: _____

(In order for your Personal Care Attendant to ride with you at no charge, you must inform the reservation/dispatch office staff that you will be accompanied by a Personal Care Attendant when making your ride request. The Personal Care Attendant is then responsible for assisting you, not the ADA Paratransit Driver.)

37. Reasonable Modification Request (Optional) Describe any modifications to Coralville Transit’s policies, practices, or procedures in order for you (an individual with disabilities) to access Coralville Transit services. (These requests may also be made as your schedule your service for ADA Paratransit rides.)

Coralville Transit is committed to providing safe, reliable, courteous, and accessible user friendly services to its customers. To ensure equality and fairness, Coralville Transit makes reasonable modifications to its policies, practices and procedures to avoid discrimination and to ensure programs and services are accessible to individuals with disabilities.

Boarding and Exiting the Bus

- | | Yes | No | Sometimes |
|--|-----|-----|-----------|
| 1. Do you now use regular fixed route bus service? | [] | [] | [] |
| 2. Are you able to recognize changes in your mental/emotional state that prevent you from using regular route service? | [] | [] | [] |
| 3. Do you have to go up and down steps in your home or residence? | [] | [] | [] |
| 4. Can you safely and independently walk up and down three (3) 12 inch steps? | [] | [] | [] |
| 5. Are you able to board, ride, or exit a wheelchair accessible bus without assistance? | [] | [] | [] |
| 6. Are you able to grasp handles or a railing while boarding or exiting a bus? | [] | [] | [] |
| 7. Are you able to board or exit a vehicle if it has a lift or kneeler that lowers the front of the bus? | [] | [] | [] |
| 8. Are you able to get on and off a bus without assistance? | [] | [] | [] |
| 9. If you answered No or Sometimes to questions 1 - 8, please explain: | | | |

10. Have you ever had training to learn how to travel around the community or how to use the fixed-route buses? [] Yes [] No

11. Is there something that might help you to ride the regular fixed route bus system? (Please check all that apply):

- [] Yes, if someone taught me to understand the route, schedule and fare information
- [] Yes, if someone were to show me how to ride the bus
- [] Yes, if someone showed me how to get on the bus using the lift
- [] Yes, if the bus were to come closer to where I live and need to go
- [] No, none of these would help

Release of Information

I, the applicant, understand that the purpose of this application is to determine my eligibility to use Coralville Transit's paratransit service. I hereby authorize my health care professional to release information about my disability and its effect on my ability to travel, which may be needed in connection with my request for ADA paratransit eligibility certification.

I agree to notify Coralville Transit of any changes in status of my disability that affects my ability to use paratransit service. I hereby certify that the information in this application is true and correct. I understand that falsification of the information may result in denial of service. I understand all information will be kept confidential and only the information required providing the service I request will be disclosed.

I hereby certify that I am the individual requesting certification for ADA paratransit service and that all information contained in this application is true and accurate:

Signed: _____ Date: _____

Printed Name of Applicant: _____

If the applicant is a minor or has a legal guardian the parent or guardian must sign this Application, and attest to the accuracy of the information contained herein.

Signature of Parent or Legal Guardian:

_____ Date: _____

Relationship to Applicant _____ Phone: _____

The next part of the application must be filled out by a health care or human services professional who is familiar with the applicant's disabling condition and/or functional limitation.

In the space provided below, CLEARLY PRINT the name of the Professional who will be verifying your application, and specify his/her position.

Name of professional _____

Professional affiliation:

- | | |
|---|--|
| <input type="checkbox"/> licensed physician | <input type="checkbox"/> licensed physical therapist |
| <input type="checkbox"/> licensed occupational therapist | <input type="checkbox"/> licensed social worker |
| <input type="checkbox"/> nurse (LPN or RN) | <input type="checkbox"/> certified psychologist |
| <input type="checkbox"/> certified rehabilitation | <input type="checkbox"/> speech pathologist |
| <input type="checkbox"/> vision specialist | <input type="checkbox"/> orientation/mobility specialist |
| <input type="checkbox"/> Psychiatrist, psychologist or
mental health counselor | <input type="checkbox"/> audiologist/hearing specialist |
| | <input type="checkbox"/> ophthalmologist |

Physician's Verification of Disability

THIS PORTION OF THE FORM MUST BE COMPLETED AND SIGNED BY AN APPROPRIATE MEDICAL, CERTIFIED OR LICENSED PROFESSIONAL WHO IS TREATING THE APPLICANT

Dear Health Care Professional:

The Americans with Disabilities Act of 1990 (ADA) requires public transit agencies to provide paratransit service to people whose disabilities prevent them from using a bus some or all of the time. Disability alone and distance to and from a bus stop **DO NOT**, by themselves, qualify a person for ADA Para-transit service. Inconvenience and/or decreased comfort **ARE NOT** a basis for qualification. The client's condition must **PREVENT** travel by bus. The information you provide will enable us to make an appropriate determination for this applicant. All information will be kept confidential. *Thank you for your assistance.*

Client Name _____

Please do not list "diagnosis" as the reason the applicant needs paratransit door to door service. We need detailed information about how the condition or disability makes it functionally impossible for the applicant to utilize our regular fixed route bus service. Our evaluation is a transportation decision, not a medical authorization.

The law is very specific as to whom and under what circumstances eligibility may be granted to use Coralville Transit's ADA Para-transit transportation.

All Coralville Transit buses have ACCESSIBLE features:

- All are equipped with wheelchair lifts or ramps, along with securement devices.
- Most buses have a kneeling capability. (Can be lowered to provide easier boarding)
- Approximately 50% of the buses have only one step up from the curb.
- Bus operators announce transfer points and all requested stops.
- Customer Service phone line(s) are available to provide bus schedule information and assist customers with their trip routing, including transfers between bus routes.

CORALVILLE TRANSIT
319-248-1790
900 10TH STREET
CORALVILLE, IA 52241

Medical/Professional Verification

(Not a request for copies of medical records)

Applicant's Name: _____

1. Please indicate date of your most recent examination of this applicant: _____/_____/_____

2. Does the applicant have the Mental Capacity to:

Give addresses and phone numbers? Yes No

Recognize a destination or landmark? Yes No

Deal with unexpected change(s) in routine? Yes No

Ask for, understand and follow directions? Yes No

Travel safely/effectively through crowded or complex facilities? Yes No

3. Specify which functional limitations are associated with this applicant's condition (check all that apply):

mobility impairment cognitive impairment** compromised endurance

muscular respiratory other _____

visual impairment total partial

hearing impairment total partial

**If this individual has a cognitive impairment, please indicate all that apply to this individual:

Cannot be left alone to wait for transportation

Displays behavior that is unsafe for self or others using public transportation

Cannot recognize vehicles that she/he should board

4. What is the expected duration of this individual's condition?

Permanent Temporary _____/_____/_____ Date

5. Does the applicant use a mobility device? Please check all that apply.

cane extra-large wheelchair prosthesis

long white cane power wheelchair communication board

portable oxygen manual wheelchair other _____

walker power scooter/cart none

crutches service animal unknown

6. How far can the applicant travel to/from a bus stop or destination? Please check.

Walking without assistance

Unable to travel any distance

The length of one football field? (300 feet)

Less than one city block? (500 feet)

One length of a football field and back? (600 feet)

One lap around a track? (1,320 feet)

Using Mobility Device

Unable to travel any distance

The length of one football field?

Less than one city block?

One length of a football field and back?

One lap around a track?

7. How long can the applicant wait outside at a bus stop?

	<u>Sitting</u>	<u>Standing</u>	<u>Using Mobility Device</u>
Unable to wait	[]	[]	[]
0 – 5 minutes	[]	[]	[]
5 – 10 minutes	[]	[]	[]
10 – 20 minutes	[]	[]	[]
20 + minutes	[]	[]	[]

8. Does the disability/condition prevent the applicant from riding a wheelchair accessible bus?

[] Yes

[] No

[] Sometimes; explain _____

9. Does weather affect the applicant's ability to travel?

[] Yes

[] No

[] Sometimes; explain _____

10. Does the applicant have medically defined temperature sensitivity? [] Yes [] No

Above what temperature for heat sensitivity? _____

Below what temperature for cold sensitivity? _____

11. Does the applicant have any other medical condition of which Coralville Transit should be aware?

12. Please describe the impact this disability/condition has on the applicant's ability to use the city buses:

Does the Applicant require a Personal Care Attendant when traveling? [] Yes [] No

A Personal Care Attendant (PCA) is not a companion or escort, but someone who will help the client with his/her mobility assistance, personal care, communication, transportation, sign language interpretation, providing services as a reader, etc., as the client makes his/her trip.

Visual Impairment Verification *(If Applicable)*

(Not a request for copies of medical records)

Please describe the applicant’s disability/condition in layman’s terminology:

What is the applicant’s best corrected vision in each eye? Right Eye:20/____ Left Eye:20/____

How long has the applicant had this visual impairment? _____

Is the applicant’s visual impairment permanent? [] Yes [] No

Does the visual impairment prevent applicant from riding a wheelchair accessible bus? [] Yes [] No

Hearing Impairment Verification *(If Applicable)*

(Not a request for copies of medical records)

Please describe the applicant’s disability/condition in layman’s terminology:

Does the hearing impairment prevent applicant from riding a wheelchair accessible bus? [] Yes [] No

Cognitively Impairment Verification *(If Applicable)*

(Not a request for copies of medical records)

Please describe the applicant’s disability/condition in layman’s terminology:

What was the onset date of these conditions? (Month/year) _____

[] Permanent condition [] Temporary

If temporary, what is the expected duration of this individual’s condition? ____/____/____

CERTIFICATION:

I certify that the information I have provided herein is a fair representation of this applicant's medical impairment or condition and is accurate to the best of my knowledge. I understand the information provided hereto will be used for the sole purpose of determining the applicant's eligibility for paratransit services. I also agree that Coralville Transit may contact me for clarification of any information I have provided and I will reply in good faith. I certify that the information contained herein is true and correct to the best of my knowledge and ability.

Health Care Professional Completing Form (name): _____

Medical License Number: _____ Telephone: _____ Fax: _____

Institution/Facility/Agency Name _____

Street _____ City _____ State _____ Zip Code _____

Signature of Health Care Professional _____

Coralville Transit Office Use Only

Date Certification Received

Certification Date: ____/____/____

Type

Conditional Eligibility _____

Unconditional Eligibility _____

Temporary Eligibility _____

Date Certification Denied ____/____/____

Denied Reason:

Appeal Received Date: ____/____/____ MPOJC Received Date: ____/____/____

MPOJC Decision: _____ Date: ____/____/____
