

ADA

DEMAND RESPONSE

Service Application

download this printable version of the application and mail it to:

SRTA

700 Pleasant Street, 1st Floor

New Bedford, MA 02740

If you have any questions please contact us at (508) 997-6767, or at our email address: srtaservice@aol.com.

INFORMATION OBTAINED IN THIS CERTIFICATION PROCESS WILL ONLY BE USED BY THE SOUTHEASTERN REGIONAL TRANSIT AUTHORITY 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.

(Return completed application to:

SRTA, 700 Pleasant Street, Suite #1, New Bedford, MA 02740)

--- PLEASE PRINT ---

1. Name: _____

(last) (first) (middle initial)

2. Address _____

(street) (apt. #)

(city/town) (state) (zip)

3. Mailing Address *(If Different)*

(street) (p.o. box #) (city/town) (state) (zip)

4. Telephone Number: *(home)* _____ *(work)* _____

5. Date of Birth: _____ Soc. Sec. #: (not required) _____

6. How does this disability prevent you from using fixed route service?

Please explain completely. Use an additional sheet if needed.

Is this condition temporary? _____ If Yes, expected length: _____

7. Are there any other effects of your disability of which we need to be aware?

8. Do you have an email address:? _____ (Yes/No)

If so what is it? _____

THE FOLLOWING INFORMATION WILL BE USED TO ENSURE THAT THE APPROPRIATE SERVICE IS PROVIDED TO YOU AND THAT AN ACCURATE ANALYSIS OF YOUR TRIP REQUESTS CAN BE MADE BY THE SOUTHEASTERN REGIONAL TRANSIT AUTHORITY.

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

Manual wheelchair ____ Power scooter ____ Powered chair ____

Cane ____ Walker ____ Crutches ____ Braces ____ Aide dog ____

10. Please answer the following questions:

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

Yes ____ No ____ Sometimes (explain) _____

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

Yes ____ No ____ Sometimes (explain) _____

Can you travel 3/4 of a mile without assistance of another person?

Yes ____ No ____ Sometimes (explain) _____

Can you climb three (3) 12 inch steps without assistance?

Yes ____ No ____ Sometimes (explain) _____

Can you use fixed route buses if they have wheelchair lifts / kneeling steps?

Yes ____ No ____ Sometimes (explain) _____

Can you wait outside without support for ten minutes?

Yes ____ No ____ Sometimes (explain) _____

Can you deal with unexpected situations or routines?

Yes ____ No ____ Sometimes (explain) _____

Can you follow directions or give requested information?

Yes _____ No _____ Sometimes (explain) _____

Can you travel through crowded terminals?

Yes _____ No _____ Sometimes (explain) _____

I HEREBY CERTIFY THAT THE INFORMATION GIVEN ABOVE IS CORRECT.

Signed _____ **Date** ___/___/___

IN ORDER TO ALLOW SRTA TO EVALUATE YOUR REQUEST, PLEASE CONTACT A PHYSICIAN, HEALTH CARE PROFESSIONAL OR OTHER PROFESSIONAL TO CONFIRM THE INFORMATION YOU HAVE PROVIDED. PLEASE HAVE THE FOLLOWING INFORMATION PROVIDED TO THE AUTHORITY. ALL QUESTIONS MUST BE ANSWERED BEFORE A DETERMINATION CAN BE MADE.

THE ATTACHED INFORMATION HAS BEEN SUBMITTED TO SRTA BY THE APPLICANT. SRTA ASKS THAT YOU PROVIDE INFORMATION REGARDING HIS/HER DISABILITY AND ITS IMPACT UPON HIS/HER ABILITY TO UTILIZE OUR TRANSIT SERVICES. FEDERAL LAW REQUIRES THAT SRTA PROVIDE PARATRANSIT SERVICES TO PERSONS WHO CANNOT UTILIZE AVAILABLE FIXED ROUTE SERVICES. A PERSON MUST HAVE AN ACTUAL PHYSICAL OR MENTAL FUNCTIONAL LIMITATION THAT DOES NOT ALLOW THEM TO USE REGULAR ACCESSIBLE PUBLIC TRANSPORTATION. A MEDICAL DIAGNOSIS OF AN ILLNESS OR MEDICAL CONDITION DOES NOT AUTOMATICALLY MAKE THE APPLICANT ELIGIBLE FOR SERVICE. THE INFORMATION THAT YOU PROVIDE WILL ALLOW US TO MAKE AN APPROPRIATE EVALUATION OF THIS REQUEST AND ITS APPLICATION TO SPECIFIC TRIP REQUESTS. THANK YOU FOR YOUR COOPERATION IN THIS MATTER.

1. Capacity in which you know the applicant:

2. Condition preventing or limiting the applicant from using regular fixed route service:
(Diagnosis- Certified MUST complete)

3. Is the condition temporary? **Yes / No** _____ Expected duration: until __/__/__

4. If the person has a disability effecting mobility can the person:

Travel 200 feet without assistance? Yes _____ No _____

Travel 1/4 mile without assistance? Yes _____ No _____

Travel 3/4 mile without assistance? Yes _____ No _____

Climb three (3) 12 inch steps without assistance? Yes _____ No _____

Wait outside without support for 10 minutes? Yes _____ No _____

IF "YES" TO ANY OF THE ABOVE QUESTIONS: Can the applicant use regular fixed route service if that service has wheelchair lifts or kneeling steps?

Yes _____ No _____

5. Does the client require a Personal Care Attendant when traveling?

Yes / No (circle one)

6. Does the client use any of the following aids to mobility? (Check all that apply)

Manual wheelchair ____ Power scooter ____ Powered chair ____

Cane ____ Walker ____ Crutches ____ Braces ____ Aide dog ____

7. Is the person effected by certain weather / climate conditions or geographical features which prevents him/her from using fixed route service?

WEATHER: Cold / Ice _____ Heat / Humidity _____

PHYSICAL TERRAIN: (SPECIFY) _____

8. If the person has a visual impairment:

Visual acuity with best correction:

Right Eye _____ Left Eye _____ Both Eyes _____

Visual fields:

Right Eye _____ Left Eye _____ Both Eyes _____

9. 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 ____

Ask for, understand and follow directions?

Yes ____ No ____

Safely and effectively travel through crowded and/or complex facilities?

Yes ____ No ____

10. Are there any other problems of which SRTA should be aware? **Please describe**

Certifier's Name (Please Print): _____

Office Address: _____

Office Phone Number: _____

Signature: _____ Title: _____

(NOTE: FAILURE TO ANSWER THESE QUESTIONS MAY DELAY OR JEOPARDIZE THE CERTIFICATION FOR SERVICE.)

- Office Use Only -

Date Received: _____ Certification #: _____ Category: _____

Comments:

PM5-ADAPP-2/10/04