Demand Response Application

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 Admin. Offices, 700 Pleasant Street, Suite #320, 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:

6. What disability prevents you from using our fixed route service?

Is this condition temporary?

If Yes, expected length:

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

Please explain completely. Use an additional sheet if needed.

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

**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 SOUTHEAST· ERN 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 *I* 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 AU­ THORITY. ALL QUESTIONS MUST BE ANSWERED BEFORE A DETERMI­ NATION CAN BE MADE.

THE ATTACHED INFORMATION HAS BEEN SUBMITTED TO SRTA BY THE APPLICANT. SRTA ASKS THAT YOU PROVIDE INFORMATION RE­ GARDING 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 MEDI­ CAL 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: CERTIFIER MUST COMPLETE!***)

Please fill in: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Is the condition temporary? Yes *I* 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 (PCA) when traveling?

Yes *I* 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 *I* climate conditions or geographical features which prevents him/her from using fixed route service? WEATHER: Cold /Ice\_\_\_\_\_ Heat *I* 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?

*(NOTE: FAILURE TO ANSWER THESE QUESTIONS MAY DELAY OR JEOPARDIZE THE CERTIFICA· TION FOR SERVICE.)*

Certifier's Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_

Office Address:

Office Phone Number: \_\_\_\_\_\_\_\_ License Number/State: \_\_\_\_\_\_\_\_\_\_\_

Signature: Title: \_ \_