CITY OF BANGOR

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COMMUNITY CONNECTOR

# ADA Complementary Paratransit Eligibility Application &Verification Form

**ALL PAGES MUST BE FILLED OUT AND RETURNED TOGETHER**

The Community Connector will be responsible for certifying the ADA complementary paratransit eligibility of each client. A determination of eligibility will be made within 21 days of the completed application process. Certified individuals will be provided with a documentation of eligibility. Those individuals that are denied eligibility will be informed in writing. Those individuals that are certified eligible with certain conditions will be informed in writing of the nature of the conditions and the documentation sent to the applicant will indicate the conditions placed on the paratransit eligibility.

**Please complete all the questions on this form**

1. Name _____
Last First Middle Initial

2. Address _____

_____

3. Telephone (____)-___ - _____ 4. Date of Birth ___/____/_____

5. Describe your disability and how you believe it prevents or limits your use of the regular transit bus. Please be specific.

6. Is this condition/s temporary? ◯yes ◯no
If temporary, what is the expected duration?

7. How do you travel now?
◯Walk ◯Drive a car ◯Ride in a Car ◯Taxi ◯Fixed Route ◯Paratransit
◯Fixed Route & Paratransit ◯Other

8. Do you need assistance when you travel in the community?
◯Yes ◯No ◯Sometimes
What type of assistance do they provide you?

Applicant:_____

9. Which of these aids do you currently use when traveling?

- ◯ Portable Oxygen
- ◯ Straight Cane
- ◯ -4 Pronged Cane
- ◯ Walker
- ◯ White Cane
- ◯ Human Guide
- ◯ Service Animal
- ◯ Crutches
- ◯ Leg Brace
- ◯ Prosthetic Leg
- ◯ Manual Wheelchair
- ◯ Power Wheelchair
- ◯ Power Scooter
- ◯ Rollator
- ◯ Alphabet/Picture Board
- ◯ Other (Be Specific)_____

If you use a wheelchair or scooter, is it considered extra wide? ◯ Yes ◯ No

10. Can you climb three steps (11 to 15 inches) with a handrail without assistance from another person?

◯ Yes ◯ No ◯ Sometimes

11. How far can you walk without the assistance of another person?

◯ Less than 100 feet ◯ 100-200 feet ◯ 201-400 ◯ 401-600 feet ◯ 601-800 feet
◯ 801-1,000 feet ◯ Over 1,000 feet ◯ Do not need assistance

12. Does weather impact your ability to use the regular transit bus?

◯ Yes ◯ No ◯ Sometimes

How?

13. Are you able to get to the closest transit bus stop from your home?

◯ Yes ◯ No ◯ Sometimes

If no, or sometimes, what prevents you?

14. Describe the terrain around your home or apartment in relation to getting to the transit bus stop (sidewalks, hills, grass, gravel, distance, etc).

15. Can you cross at traffic lights? ◯ Yes ◯ No ◯ Sometimes

If no or sometimes, What prevents you?

Applicant:_____

16. Can you cross streets with very little traffic, where there are no traffic controls or stop signs without assistance?

◯Yes ◯No ◯Sometimes

If no or sometimes, what prevents you?

17. Can you cross at busy intersections? ◯Yes ◯No ◯Sometimes

If no or sometimes, what prevents you?

18. Can you wait at a transit bus stop? ◯Yes ◯No

If no, please explain why.

19. Are you able to ask for, and follow, written or oral information?

◯Yes ◯No ◯Sometimes

If no or sometimes, what prevents you?

20. Are you able to recognize your destination or landmark near your destination?

◯Yes ◯No ◯Sometimes

If no or sometimes, what prevents you?

21. Are you able to tell time? ◯Yes ◯No

22. Are you able to count money? ◯Yes ◯No

23. Is there any other information you want to provide that will help us in making an appropriate eligibility determination?

Applicant:_____

24. From the following list, please mark all the of the disabilities or symptoms that prevent you from boarding, riding, or disembarking from public transit buses:"

**Cardiovascular/Pulmonary**

- ◯ Angina
- ◯ Arteriosclerosis/Atherosclerosis
- ◯ Asthma
- ◯ Bypass Surgery Date: _____
- ◯ Chronic Obstructive Pulmonary Disease
- ◯ Congestive Heart Failure
- ◯ Cystic Fibrosis
- ◯ Emphysema
- ◯ Heart Attack Date: _____
- ◯ HTN/Hypertension
- ◯ Peripheral Vascular Disease
- ◯ Phlebitis
- ◯ Thrombosis
- ◯ Other _____

**General Medicine**

- ◯ AIDS
- ◯ Atrophy
- ◯ Chemotherapy
- ◯ Diabetes
- ◯ Edema
- ◯ Epilepsy
- ◯ Lupus
- ◯ Rheumatoid Arthritis
- ◯ Kidney Dialysis
- ◯ Radation Treatment
- ◯ Other _____

| **Vision (specify)** | **One Eye** | **Both Eyes** |
|---|---|---|
| ◯ Cataracts | _____ | _____ |
| ◯ Cortical Blindness | _____ | _____ |
| ◯ Glaucoma | _____ | _____ |
| ◯ Macular Degeneration | _____ | _____ |
| ◯ Retinal Detachment | _____ | _____ |
| ◯ Legally Blind | _____ | _____ |
| ◯ Totally Blind | _____ | _____ |

◯ Other _____

**Neuromuscular**

- ◯ ALS/Lou Gehrig's Disease
- ◯ Cerebal Palsy
- ◯ Charcot-Marie Tooth Syndrome
- ◯ Equilibrium
- ◯ Fibromyalgia
- ◯ Hemiplegia/Hemiparesis
- ◯ Multiple Sclerosis
- ◯ Muscular Dystrophy
- ◯ Neuropathy
- ◯ Paraplegia
- ◯ Parkinson's Disease
- ◯ Polio
- ◯ Quadriplegia
- ◯ Sciatica
- ◯ Spina Bifida
- ◯ Stroke/Cerebral Trauma Date: _____
- ◯ TIA's (Transient Ischemic Attack)
- ◯ Other _____

**Orthopedic**

- ◯ Amputation
- ◯ Broken/Fracture Date _____
- ◯ Degenerative Joint Disease
- ◯ Gout
- ◯ Hip Replacement
- ◯ Knee Replacement
- ◯ Osteoarthritis
- ◯ Osteoporosis
- ◯ Scoliosis
- ◯ Spondylitis
- ◯ Other _____

**Congnitive/Psychological**

- ◯ Alzheimer's Disease
- ◯ ADD/ Attention Deficit Disorder
- ◯ Autism
- ◯ Dementia
- ◯ Head Trauma
- ◯ Mental Retardation
- ◯ Panic Disorder
- ◯ Schizophrenia
- ◯ Other _____

Applicant:_____

25. For each disability marked on the previous page, please describe how it prevents you from boarding, riding, or disembarking from a transit bus?

# APPLICANT VERIFICATION

***Application must be signed to be considered complete.***

**Applicant Signature**

I understand that the purpose of this application form is to determine if there are times when I cannot use Community Connector fixed route buses and will require paratransit services. I understand that the information this application will be kept confidential and shared only with the professionals involved in evaluating my eligibility. I certify that to the best of my knowledge, the information on this application is true and correct. I understand that providing false or misleading information could result in my eligibility status being terminated.

I give permission for Community Connector staff to contact the professional who has filled out this application or given supplemental verification of my condition.

Applicant Signature X _____Date_____

Print Name_____

**Person completing this form if other than Applicant (check one):**

◯ I certify that the information in this application is true and correct based upon the information given to me by the applicant.

◯ I certify that the information provided in this application is true and correct based upon my own knowledge of the applicant's health condition or disability or I have legal authority to complete this application.

Print Name _____ Day Phone _____

Address_____City_____State____Zip_____

Signature_____Date_____

Relationship to Applicant_____

Agency Name_____

Applicant:_____

## This section is to be completed by a **Licensed/Certified** Health Care Professional who has knowledge about the applicant's functional ability.

**Who can complete this section: [must be licensed/certified]**

| | |
|---|---|
| Vocational Rehabilitation Counselor | O & M Instructor |
| Social Worker | Physician |
| Respiratory Therapist | Physician Assistant |
| Psychologist | Nurse Practitioner |
| Psychiatrist | Physical Therapist |
| Audiologist | Optometrist / Ophthalmologist |
| Independent Living Specialist | Registered Nurse |

**Dear Health Care Professional:**

In order to complete this application on behalf of the applicant, you must be either a certified or license professional. [If you feel you are qualified to complete this application as a health care professional, but do not have a certification or license number, please contact Community Connector at (207) 992-4670, and request to speak to the ADA Specialist for approval to complete.

The applicant is asking you to complete and sign this section of this application & verification form certifying that they have a disability that prevents them from using fixed route bus service (regular transit buses). This information will be used to help determine whether or not the applicant needs to use paratransit (origin to destination) service or is able to use fixed route service for all or some of their travels.

Under the Americans with Disabilities Act (ADA), if a person has the functional and cognitive ability to use Community Connector fixed route buses, that person is not eligible for paratransit services. Disability alone, distance to and from a bus stop, or the availability of fixed route bus service, is not by itself, a qualifier for paratransit services.

All Community Connector fixed route buses are lift equipped for use by individuals using wheelchairs or by individuals who are not able to use steps. Additionally, Community Connector has kneeling buses, which lowers the bus to the ground, making the first step from the curb easier to make. Community Connector also offers travel training to assist persons with disabilities to use the fixed route bus service to enhance their independence.

If you have any questions while completing this section, please contact us at (207) 992-4670.

**Required Information – Licensed/Certified Health Care Professional**

Name (Please print) _____

Signature _____

Professional Title _____

Area of Professional Specialization _____

Professional License # _____

Clinic or Agency _____

Address _____

Phone Number _____

Applicant:_____

**Questions Regarding the Applicant's Disability – Please complete all sections that apply. Incomplete applications will be returned to applicant.**

## General Medical or Physical Disability Information

Applicant has been a patient of mine since: _____
Date of applicant's last evaluation: _____

1. Please indicate the nature of your patient's condition or disability. This list is not all inclusive, it lists what we predominantly see on submitted applications.

- ◯ Diabetes
- ◯ End Stage Renal Disease
- ◯ Dialysis? Yes No
- ◯ Undergoing Cancer Treatment Expected Duration: _____
- ◯ Arthritis: Please specify type and area/s: _____
- ◯ Amputation: Please specify extremity and/or use of prosthesis: _____
- ◯ Neurological Condition/Cognitive (Circle one) Mild Moderate Severe Profound
- ◯ Neuromuscular Condition
- ◯ Pulmonary Disease: If on oxygen, what is usage:
- ◯ Cardiac Disease
- ◯ Mental Illness
- ◯ Traumatic Brain Injury
- ◯ Legally Blind
- ◯ Severely Visually Impaired
- ◯ Alzheimer's
- ◯ Dementia
- ◯ Autism
- ◯ Hearing Impairment (Specify degree of hearing loss)
- ◯ Seizures
- ◯ Other _____

2. Are the condition/s temporary? ◯Yes ◯No

If temporary, what is the expected duration?

3. Are there environmental conditions that would have a negative impact on the applicant's condition/s?

◯Yes ◯No

What are the conditions? _____

What is the impact? _____

4. Do you feel the applicant could be trained to independently use regular city ransit stops safely and effectively? ◯Yes ◯No If no, why?

Applicant:_____

5. How far do you feel the applicant could independently propel a wheelchair or ambulate with or without a mobility aid, and without lengthy rest breaks?

◯No independent functional mobility ◯Less than ½ mile

◯ _____ Blocks (500 feet = 1 block) ◯Greater than ½ mile

6. How long can the applicant wait at a transit bus stop with a bench/shelter? _____

7. How long can the applicant wait at a transit bus stop without a bench/shelter?_____

8. Seizure Disorders

Type(s) of seizures? _____

How often do the seizures occur?_____

After a seizure, how long does it take before the applicant is able to function safely?

_____

Are the seizures preceded by an aura? ◯Yes ◯No

What triggers the applicant's seizure? _____

_____

Is the applicant taking medication for the seizures? ◯Yes ◯No

Are the seizures currently controlled? ◯Yes ◯No

Is he/she able to function safely and effectively in the community? ◯Yes ◯No

When was the applicant's last seizure? _____

## Cognitive Disability

9. What is the formal diagnosis of the applicant's condition? _____

10. Does the applicant have any specific behavioral problems? ◯Yes ◯No

If Yes, describe:

11. Is the applicant able to travel alone? ◯Yes ◯No

12. Does the applicant have the ability to follow directions?

◯1 Step Directions ◯2 Step Directions ◯3 Step Directions ◯None

13. Would the applicant know what to do if he/she became lost while out in the community?

◯Yes ◯No

14. Does the applicant have the ability to safely cross streets? ◯Yes ◯No

Applicant:_____

15. Please check all that apply to applicant and provide additional information if necessary:
- ◯ Problem Solving
- ◯ Short-term Memory
- ◯ Attention
- ◯ Processing
- ◯ Foresight/Planning
- ◯ Safety Awareness/Judgment

How would these prevent the applicant from being able to safely use regular city buses?

_____

_____

16. Is the applicant currently enrolled in any programs? ◯Yes ◯No
If yes, please list:

## Behavioral Health

17. What is the formal diagnosis of the applicant's condition? _____

18. What is the prognosis for this condition for independent function?_____

19. Has the applicant been prescribed medications for his/her condition? ◯Yes ◯No
If yes, does this medication allow the applicant to function safely in the community? ◯Yes ◯No

20. Has the applicant recently had a decline in function due to an adjustment in medication? ◯Yes ◯No
If yes, please describe:

21. Does the applicant experience auditory or visual hallucinations? ◯Yes ◯No
If yes, how do the hallucinations impair the applicant's ability to function in the community?

22. Does the applicant have anxiety or panic attacks in closed/crowded spaces? ◯Yes ◯No
If yes, please explain:

23. Are there life skills that the applicant lacks that would prevent him/her from safely using regular transit buses? ◯Yes ◯No If yes, please explain:

Applicant:_____

## Vision Disability

24. What is the formal diagnosis of the applicant's condition? _____

25. Best Corrected Vision: _____

26. What is the prognosis? Is this condition stable, degenerative or otherwise changing?

27. Is the individual able to walk outdoors alone? ◯Yes ◯No

If yes, where can the applicant walk?

◯ Only on his/her own property and to familiar places
◯ To places nearby (for example, on the same block)
◯ To places further away

28. If applicant is able to travel outdoors alone, is he/she able to cross streets without help?

◯ At quiet streets with very little traffic
◯ At traffic lights
◯ At busy intersections
◯ With auditory cross signals only
◯ Other: _____

29. Is he/she able to see steps or curbs? ◯Yes ◯No

28. Is his/her vision affected by different lighting conditions?

◯ Bright sunlight
◯ Dimly lit or shaded places
◯ Nighttime
◯ Other: _____

29. Is the applicant's ability to travel outside alone affected by other conditions? ◯Yes ◯No

If yes, please explain:

30. Is there any other information you want to provide that will help us in making an appropriate eligibility determination?

◯ I certify that the information is true, and correct to the best of my knowledge.

Signature: _____

Title: _____ Date: _____