



ADA Paratransit Certification Application

Citilink Access Service is a shared ride, public paratransit service for people with disabilities who are unable to use regular accessible Citilink fixed route service for some, or all of their public transportation needs due to their disability. The Americans with Disabilities Act (ADA) outlines specific criteria to determine eligibility for paratransit service.

The existence of a disability does not, in itself, qualify you for paratransit service. Eligibility is based solely on your functional ability to use the fixed route bus. If the effects of your disability prevent you from getting to or from a bus stop, waiting for a bus, getting on or off a bus, or navigating the bus system, you may be eligible for some level of paratransit service. Eligibility determinations are based upon the limitations caused by your disability. You may qualify for partial or full service.

After you submit your completed application, we may request you to participate in an in-person interview and/or functional assessment. Your application will not be considered complete until all requested information is provided to us. Once we have received all necessary information, an eligibility determination will be made within 21 days. You will be notified by mail of the decision.

If you feel that, because of your disability, you are unable to successfully travel using the regular, fixed-route bus, some or all of the time, please complete the application form.

- Complete pages 1-6 of the application form (please print clearly).
- Ensure the applicant, parent or legal guardian, or power of attorney signs the application on page 6. A signature is required before an application will be processed.
- Ensure page 7 is completed and signed by an approved provider (see list of approved providers on page 6).
- Everything must be completed, signed, and legible or the application will be returned.
- Please return all pages of the application together. Any incomplete application will be returned.

Please mail or fax the completed and signed application as well as any supporting paperwork, to:

Citilink Paratransit Services
801 St. Francis Drive
Fort Wayne, IN 46808
Fax# 260-436-7729



The information obtained in this certification process will only be used by the Fort Wayne Transportation Corporation 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.

New Rider _____ Existing Rider _____

PART 1: Applicant Information (please write clearly)

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Gender (please circle) M F

Residence Address _____ Apt/Rm/Unit # _____

Name of Facility/Apt Complex _____

City: _____ State _____ Zip _____

Telephone (Home): _____ (Work): _____

Email Address: _____

Preferred contact method: Check one or both: Text Message: _____ Call: _____

Emergency Contact: Name _____

Relationship _____ Phone Number _____

PART 2: Qualifying Disability Information (please write clearly)

- 1. List the health condition(s) or disability that would prevent your use of the fixed route bus, some or all the time. List only the ones that impact your ability to use the regular bus. Please be specific.

2. Please indicate if your disability fits within any of the following categories:

___Physical ___Mental ___Blindness/Visual Impairment

___Deaf/Hearing Impairment ___Cognitive/Developmental ___Health Issues

3. Please explain how this disability affects your ability to use regular fixed route bus service.

How does your disability prevent you from traveling to or from a regular fixed route bus stop?

How does your disability prevent you from waiting safely at a regular fixed route bus stop?

How does your disability prevent you from getting on or off a regular bus?

How does your disability prevent you from riding a regular fixed route bus or from understanding and following transit instructions?

General:

- Are you on any medication that affects your functional abilities? Yes ___ No ___

If yes, specifically, what side effect(s) are you experiencing?

Physical mobility (if applicable): Permanent ___ Temporary (expected duration) ___

- How far can you walk, with or without a mobility aid?

200 feet: Yes ___ No ___ Sometimes ___

¼ mile: Yes ___ No ___ Sometimes ___

¾ mile: Yes ___ No ___ Sometimes ___

- Can you climb three 12-inch steps without assistance? Yes ___ No ___ Sometimes ___

- Can you wait outside without support for ten minutes? Yes ___ No ___ Sometimes ___

- Are you able to do the following with *or* without a mobility aid?

Up/down a moderately steep hill Yes ___ No ___ Sometimes ___

Uneven terrain Yes ___ No ___ Sometimes ___

Stand for 20 minutes Yes ___ No ___ Sometimes ___

Tolerate cold Yes ___ No ___ Sometimes ___

Tolerate heat Yes ___ No ___ Sometimes ___

Seizures (if applicable): Permanent _____ Temporary (expected duration) _____

- Type and frequency of seizure? _____

Vision (if applicable): Permanent _____ Temporary (expected duration) _____

- What is your corrected visual acuity? R: _____ L: _____
- Have you had mobility training related to your vision impairment?
Yes _____ No _____ Unknown _____

Cognitive (if applicable): Permanent _____ Temporary (expected duration) _____

- Can you give addresses and phone numbers upon request? Yes _____ No _____
- Can you recognize a destination or landmark? Yes _____ No _____
- Can you deal with unexpected situations or unexpected change in routine? Yes _____ No _____
- Can you inquire, understand, and follow directions? Yes _____ No _____
- Can you safely and effectively travel through crowded and/or complex facilities? Yes _____ No _____

Psychological (if applicable): Permanent _____ Temporary (expected duration) _____

- Please answer questions under Cognitive section above.
- Are there any behavioral issues that would impact your use of public transportation (which is what paratransit is)? If so, what are they?

- Are your mental health issues currently controlled by medication? Yes _____ No _____ Sometimes _____

PART 3: Mobility (please write clearly):

1. How have you most recently been traveling? Check all that apply

- _____ Citilink Fixed Route _____ Taxi _____ Drive
_____ Ride in a car _____ Bicycle _____ Walk
_____ Private transportation company _____ Other (please specify)

2. Have you ever used the regular, fixed route buses independently?

- _____ Yes, I typically use the regular buses _____ times a week.
_____ Yes, I used to but stopped because (please be specific)

_____ No

3. What accommodation would assist you in using the fixed route bus system?

- ___ Route & schedule information ___ Bus stops closer to home/destination
___ Accessible bus stop and pathway ___ Bench/shelter at bus stop
___ No transfers ___ Training to use the fixed route bus
___ Other

4. Because of your disability, do weather conditions (such as heat, cold, rain, snow, or ice), terrain conditions (such as hills, uneven surfaces, or curbs), or environmental conditions (such as darkness, bright lighting, or air quality) prevent you from using a regular bus independently? Yes _____ No _____

If yes, please explain (which ones and how?) _____

5. Which of the following mobility aids or equipment do you use when you travel outside of your home? Check all that apply and indicate the percentage of time you use the aid. (Example: support cane 90%, no aids 10%)

No aids	_____ %	Power scooter	_____ %
White cane	_____ %	Manual wheelchair	_____ %
Support cane	_____ %	Guide Dog	_____ %
Crutches	_____ %	Personal Care Attendant	_____ %
Portable Oxygen	_____ %	Other (please specify)	_____ %
Walker	_____ %	_____	_____ %
Power wheelchair	_____ %		

6. If you use a wheelchair or scooter, is your combined weight (you and the wheelchair/scooter) more than 600lbs? _____ Yes _____ No

If yes, what is the combined weight? _____

If you use a manual wheelchair, how far are you able to self-propel? _____

If you use a power wheelchair/scooter, how far are you able to travel outside on your own and what would limit your abilities?

PART 4: Application Verification

I agree the information provided on this application is true and correct to the best of my knowledge. The purpose of this application is to determine if I am eligible to use Paratransit services, or if at times I can ride the fixed route buses. I understand that falsification of information could result in loss of Paratransit services as well as a penalty under the law.

I agree to notify Citilink if my condition changes, if my mobility device has been replaced, if I have a new mobility device, or if I no longer need to use Paratransit service.

Signature of Applicant or Legal Guardian Date _____

Person completing application *if not* the applicant:

Printed Name Relationship to Applicant

Signature Date

Contact Phone #

This concludes the applicant’s portion of the application. The following pages MUST be completed by a licensed Medical or Mental Health provider who is most familiar with you and your disability/limiting condition.

Approved providers are limited to the following professions. Please check the appropriate box for your approved provider.

- | | |
|----------------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Medical Doctor (MD or DO) | <input type="checkbox"/> Psychologist (Ph.D.) |
| <input type="checkbox"/> Physician Assistant or ARNP | <input type="checkbox"/> Mental Health Clinician III or IV |
| <input type="checkbox"/> Ophthalmologist or Optometrist | <input type="checkbox"/> Audiologist (certified by ASHA) |
| <input type="checkbox"/> Certified Orientation & Mobility Specialist | <input type="checkbox"/> LICSW (employed at medical facility) |

PART 5: Professional Verification

Applicant Name _____

Thank you for completing this application. We will use this information to help determine paratransit eligibility in accordance with the Americans with Disabilities Act (ADA). Paratransit is a tax-supported service for individuals who, because of the effects of their disabilities/limit conditions, are not able to ride the regular ramp-equipped and accessible bus. **Age, language, convenience of the service, fear of falling, inability to drive, and inability to carry packages are NOT qualifying factors for paratransit service.** Please call 260-432-4977 if you have any questions.

Please review the information provided by the applicant on this application form. Based on your knowledge of the applicant’s condition, is the information accurate?

_____ Yes _____ No _____ Somewhat

If you checked *No* or *Somewhat*, please explain _____

On page 4, if the applicant marked that they need a Personal Care Attendant (PCA) to ride with them, please explain why the PCA is needed and what type of assistance the PCA would provide to the applicant.

Are there any changes or additions you would make to the list of stated Diagnosis/Disability shown on page 1, Part 2 of this application? _____

Provide any additional information that you deem relevant as to why the effects of the applicant’s disability/limiting condition will prevent their use of the regular, fixed route bus system.

I am an approved provider (see page 6), licensed in the State of Indiana in the field indicated below, and certify that the above-mentioned individual has the disability and limitations indicated above.

Professional Care Provider’s Signature

Date

Professional Care Provider’s Name (please print)

Phone #

Mailing Address

Clinic Name

Individual National Provider Identifier (NPI) or IN DOH License number

*This form is considered Incomplete without valid individual number.