Clermont Transportation Connection
4003 Filager Rd - Batavia, OH 45103
Dispatch 513.732.7433 - Operations 513.732.7578 - Director 513.732.7577

CTC is committed to ensuring equal access to its services for all individuals, regardless of disability. All of the information provided in this application is confidential and serves to determine eligibility only. If you meet the eligibility criteria, you will be scheduled for an interview for final eligibility status determination.

PART A: APPLICANT

NOTE: PLEASE ANSWER ALL QUESTIONS.

INCOMPLETE APPLICATIONS CANNOT BE PROCESSED.

Please Type or Print Clearly

Applicant Name: (First, Last, Initial) _____

Home Address: _____ Apt# _____

City: _____ State: _____ Zip Code: _____

❑ New Application ❑ Renewal Application ❑ Temporary Application ❑ Visitor Application

Home Phone #: _____ Second (Evening) Phone #: _____

❑ Male ❑ Female Date of Birth: _____/_____/_____ SSN _____-_____-_____

Required for Verification Purposes

I certify that the information provided in this application is true and correct

_____ _____

Signature Date

==========

To be completed if the applicant was helped by another person in the completion of the application.

Name _____ Daytime Phone _____

Relationship _____ Date _____

Will you need future materials in an accessible format? If yes, circle one:

Braille Large Print Audio Cassette Computer Disc

Person or agency to contact in case of an emergency:

Name _____ Relationship _____

Street _____ Apt# _____ Bldg # _____

City: _____ State _____ Zip code: _____

Home Phone: _____ Work Phone: _____

PART B: APPLYING FOR ADA CERTIFICATION

1. What are all of your current means of transportation? Please check all that apply.

- ❑ Walking
- ❑ Mobility aids or equipment
- ❑ Public transit bus
- ❑ Paratransit van
- ❑ Automobile
- ❑ Taxi/car service
- ❑ Commuter railroad
- ❑ Medicaid transportation
- ❑ Other_____

2. Which of the following mobility aids or equipment do you use to help you get to where you need to go? Please check all that apply.

- ❑ Manual wheelchair
- ❑ Power scooter
- ❑ Walker
- ❑ Cane
- ❑ Crutches
- ❑ Prosthetic device/brace
- ❑ Respirator/Oxygen tanks
- ❑ Guide can
- ❑ Service animal (guide dog, etc)
- ❑ I do not use a mobility aid
- ❑ Other_____

(Note: We may not be able to accommodate you if your wheelchair or scooter is longer than 48", wider than 30", or if your total weight with your mobility device is more than 600 pounds)

3. Using a mobility aid, equipment or standing on your own, what is the longest length of time that you can wait for transportation?

- ❑ 1-15 minutes
- ❑ 15-30 minutes
- ❑ 30-45 minutes
- ❑ 45-60 minutes
- ❑ Over 60 minutes
- ❑ I cannot wait without assistance

4. Using a mobility aid, equipment or walking on your own, how many blocks can you travel on level ground? Circle the answer below that best describes your situation.

1-2 blocks	Never	Sometimes	Always
2-4 blocks	Never	Sometimes	Always
4-6 blocks	Never	Sometimes	Always
6-8 blocks	Never	Sometimes	Always
Over 8 blocks	Never	Sometimes	Always

5. How far is the closest CTC fixed route and/or shuttle stop to your home?

- ❑ 0 – 1 block
- ❑ 2 - 4 blocks
- ❑ 4 - 6 blocks
- ❑ 6 - 8 blocks
- ❑ over 8 blocks
- ❑ I don't know

6. Do you currently use the CTC fixed route and/or shuttle system?

❑ Yes ❑ No

- If yes, how many days in one week _____
- If no, please check all that apply:
  - ❑ I have a disability which prevents me from boarding a regular CTC bus which does NOT have a lift
  - ❑ I have a disability that prevents me from boarding a CTC bus with a lift.
  - ❑ I have a disability that prevents me from getting to some bus and/or shuttle stops.
  - ❑ I have a disability that prevents me from getting to ALL bus and/or shuttle stops.
  - ❑ I am afraid to ride the CTC bus.
  - ❑ I have no knowledge of or experience with the CTC transportation system, so I do not know if I am able to use it.
  - ❑ There is no CTC bus stop near my residence.
  - ❑ I cannot get to a bus stop by myself because I get disoriented or confused.
  - ❑ I have a temporary disability that prevents me from taking a regular CTC bus. I will only need to use the paratransit service until I recover.
  - ❑ If given information, instructions or training on the CTC bus service, I think I could use it.
  - ❑ My trip by CTC and/or shuttle bus would take me too long.
  - ❑ I have an episodic disability. I can use the bus on those days when I am feeling well, but on "bad days", I cannot.

7. Can you reach your destination from where the fixed route and/or shuttle bus stops to let you off?

❑ Yes ❑ No

- If no, please check all that apply:
  - ❑ I cannot walk that far
  - ❑ I become confused or cannot remember where I am going.
  - ❑ I do not want to ride the fixed route and/or shuttle system
  - ❑ There are no curb cuts, paved sidewalks, or the ground is too uneven
  - ❑ Other (please specify)_____

8. If you do not ride the fixed route and/or shuttle system, what would help you?

- Please check all that apply:
  - ❑ Lift accessible buses.
  - ❑ Knowing more about the fixed route and/or shuttle system
  - ❑ I would travel if there were accessible fixed and/or shuttle routes where I need to go.
  - ❑ Other (please specify)_____

9. Please list the last two trips you took and how you got there:

- Origin:_____ Destination:_____

Transportation:_____

- Origin:_____ Destination:_____

Transportation:_____

10. Can you follow written or oral instructions to use the fixed route and/or shuttle system?

❑ Yes ❑ No

11. Do you need transportation at least three times each week for regularly scheduled trips to a particular destination?

❑ Yes ❑ No

- If yes, please check all that apply:

❑ Dialysis ❑ Work

❑ Therapy ❑ Adult Day Care

❑ School ❑ Senior Center

❑ Volunteer Work ❑ Other:_____

Please list the most common addresses to which or from which you travel.

_____

_____

12. Can you transfer from one regular fixed bus route and/or shuttle route to another?

❑ Yes ❑ No

- If no, please check all that apply:

❑ I get too confused and might become lost

❑ I do not like to transfer

❑ I cannot hold a paper transfer

❑ I do not want to use the fixed route and/or shuttle system

❑ Other:_____

13. Can you climb three 12-inch steps without assistance?

❑ Yes ❑ No

- If no, please explain:_____

14. Can you communicate with the bus driver by yourself?

❑ Yes ❑ No

- If no, please check all that apply:

❑ I cannot understand the driver

❑ Other people cannot understand me

❑ I need a communication aid and do not have one

❑ Other (please specify):_____

15. Do you travel with a Personal Care Attendant (PCA, e.g., a person such as a home attendant or friend who assists you when you travel outside your home)?

❑ Yes ❑ No

- If yes, please check all that apply to you:
  - ❑ Personal Care Attendant (PCA) helps me get to or from a bus and/or shuttle stop
  - ❑ Personal Care Attendant (PCA) helps me get on or off the bus
  - ❑ Personal Care Attendant (PCA) helps me while I ride the bus
  - ❑ Other (please specify):_____

16. Is your disability temporary?

❑ Yes ❑ No

- If yes, please indicate how long you believe the temporary disability will continue:
  - ❑ 1 month
  - ❑ 2 months
  - ❑ Other (how many months?)_____

17. Is your condition affected by the weather?

❑ Yes ❑ No

- If yes please explain:_____

_____

18. Is your disability permanent?

❑ Yes ❑ No

19. What kind of place do you live in? Please check one.

❑ House ❑ Assisted Living

❑ Apartment ❑ Rehab Hospital

❑ Group Home ❑ Other:_____

PART C: APPLICANT AGREEMENT AND INFORMATION

If you are not the applicant, but you completed this application on behalf of the applicant, you must provide the following information (please print or type):

Applicant's Name:_____

Name of person filling out this application:_____

Relationship to applicant:_____ Phone Number:_____

Office Street Address:_____

City:_____ State:_____ Zip:_____

I certify that the information given in this application is correct.

Signature:_____ Date:_____

AGREEMENT TO ELIGIBILITY TERMS AND CONDITIONS

(All applicants must sign this agreement)

I understand that my application will be returned if it is incomplete and this will delay the processing of my application. I affirm that all information that I provide on this application is true to the best of my knowledge. I understand that my application is subject to review and verification and that misrepresentation of any material information will lead to revocation of my registration. I also understand that failure to adhere to the policies and procedures for using the CTC paratransit service will be grounds for suspending my eligibility in this program.

X_____ _____

Applicants Signature *Date*

AMERICANS WITH DISABILITES (ADA) APPEAL PROCESS

If your ADA paratransit eligibility determination results in a finding of ineligible to receive paratransit service or in a determination of limited or conditional eligibility and you feel that this determination has been made in error, you have the right to appeal this determination.

To file this appeal you must notify CTC in writing within 60 days of the date on the determination letter. After your appeal is received, a hearing will be scheduled to evaluate your case. The hearing process (which should not take more than 30 days) will allow you to present information and arguments on your behalf. You may have others present who are knowledgeable of your physical or mental impairment and who can speak on your behalf, but you must pay the cost for these other spokespersons. After the hearing you will be advised in writing of the decision of the appeal board. The decision of the appeal board is final.

CTC is not required to provide you with paratransit service while your appeal is under consideration. If the appeal board has not made its decision within 30 days of receiving your appeal, you are entitled to paratransit service from that time until a final decision is made.

PART D: HEALTH CARE PROFESSIONAL VERIFICATION

Dear Health Care Professional:

You are being asked to complete an assessment of the applicant's disability that prevents his/her ability to use the CTC fixed route and/or shuttle bus system. By completing and signing this document you (the health care professional) will be certifying the truth and accuracy of the information provided on this application, to the best of your professional knowledge.

The Clermont Transportation Connection ADA paratransit program is partially funded through the Federal government. Federal Law (*The American with Disabilities Act of 1990*) requires that CTC provide services to persons who cannot use our fixed route bus system. However, resources for CTC paratransit services are limited. The information you provide will allow the CTC to make an appropriate evaluation of this request for paratransit service. To qualify for paratransit service, a person must be unable to use fixed route and/or shuttle system and fulfill the following eligibility criteria:

Individuals qualify if:

- As a result of their disability, they cannot board, ride or disembark from a CTC fixed route and/or shuttle bus; or
- They have a specific impairment related condition that prevents them from getting to or from a fixed bus and/or shuttle route

Please note:

- Paratransit service is a transportation service for disabled persons who, as a result of their disability, cannot board, ride or deboard from a CTC fixed route and/or shuttle bus.
  (All CTC fixed route and/or shuttle buses are handicap accessible)
- Paratransit service does not include persons who find it uncomfortable or difficult to get to and from fixed route buses

- Your verification must be filled out completely for processing to occur. **If the application is not complete it will be returned for completion, delaying the processing of the application.**

Your evaluation of each person must be based solely upon the individual's ability to use the CTC fixed route and/or shuttle bus system. Please exercise care in evaluating applicants for this program. ***False information used to acquire service for this applicant could result in travel limitations for other persons legitimately qualified to use this program.***

The following information will be used to ensure the appropriate type of vehicle is used to provide transportation.

1. Does the applicant use any mobility aids?

   ❑ Yes ❑ No

- If yes, what type?

  ❑ Manual wheelchair
  ❑ Walker
  ❑ Power wheelchair
  ❑ Power scooter
  ❑ Crutches
  ❑ Respirator/Oxygen tank
  ❑ Service animal (guide dog, etc…)
  ❑ Cane
  ❑ Guide cane
  ❑ Other:_____

2. Can the applicant transfer from a wheelchair/other mobility aid to a passenger seat if necessary?

❑ Yes ❑ No

3. Due to the applicants disability could the applicant be left unattended at a pick-up or drop-off location?

❑ Yes ❑ No

4. Please circle yes or no to indicate whether the applicant can do any of the following:

Travel 2 blocks without assistance	Yes	No
Climb three 12-inch steps without assistance	Yes	No
Wait outside without support for 30 minutes	Yes	No
Give address and phone numbers upon request	Yes	No
Recognize a destination or landmark	Yes	No
Deal with unexpected situations or changes in routine	Yes	No
Ask for, understand, and follow directions	Yes	No
Travel effectively through crowded/complex facilities	Yes	No

5. Please check all of the disabilities that would impair the applicant's ability to travel on the fixed route buses:

Neuromuscular

- ❑ Cerebral Palsy
- ❑ Muscular Dystrophy
- ❑ Parkinson's Disease
- ❑ Arthritis
- ❑ Stroke/Cerebral Trauma
- ❑ Quadriplegia
- ❑ Multiple Sclerosis
- ❑ Paraplegia
- ❑ Other:_____

General Medical

- ❑ AIDS
- ❑ Diabetes (severe)
- ❑ Lupus
- ❑ Cancer
- ❑ Epilepsy (severe)
- ❑ Kidney disease/Dialysis
- ❑ Other:_____

Cardiovascular

- ❑ Arteriosclerosis
- ❑ Cystic Fibrosis
- ❑ Emphysema
- ❑ Congestive Heart Failure
- ❑ Chronic Obstructive Pulmonary disease
- ❑ Peripheral Vascular disease
- ❑ Thrombosis (chronic)
- ❑ Asthma
- ❑ Heart Attack
- ❑ Other:_____

Cognitive/Psychological

- ❑ Alzheimer's disease
- ❑ Dementia
- ❑ Mental Retardation
- ❑ Phobia
- ❑ Head Trauma
- ❑ Panic disorder
- ❑ Autism
- ❑ Schizophrenia
- ❑ Other:_____

VISION

Check all that apply	One eye	Both eyes
Cataracts	❑	❑
Cortical Blindness	❑	❑
Glaucoma (all types)	❑	❑
Macular Degeneration	❑	❑
Retinal Detachment	❑	❑
Retinopathy	❑	❑
Legally Blind	❑	❑
Totally Blind	❑	❑
Other:	❑	❑

6. Please provide (type or print) a narrative assessment of the applicant's functional level of mobility.

_____

_____

_____

_____

_____

_____

_____

_____

HEARING

Check all that apply	One Ear	Both ears
Partially Deaf	❑	❑
Completely Deaf	❑	❑

7. Would the applicant's condition prevent him/her from using the public fixed route and/or shuttle service?

❑ Yes ❑ No

If yes, please explain in detail:_____

_____

_____

8. Is the applicant's condition temporary?

❑ Yes ❑ No

If yes, expected duration is _____months

If yes, please explain:_____

_____

9. Would the applicant be conditionally eligible for CTC paratransit service due to weather conditions?

❑ Yes ❑ No

If yes, during which months would they need service:_____

If yes, please explain:_____

_____

10. In your assessment, would you require this person to ride with a PCA? Reason to require a PCA could be any that would cause service disruptions.

❑ Yes ❑ No

If yes, please explain:_____

_____

_____

X_____ _____

Health Care Professionals Signature Daytime phone number

_____ _____

Health Care Professionals Name (please print) Date

CTC may contact the certifying Health Care Professional to verify accuracy of the information. CTC will make the final determination as to the applicant's eligibility.

Thank you for your assistance.

FOR CTC USE ONLY
DO NOT WRITE IN THIS BOX

Application Received: _____ Certification Date: _____ Status: ❑ Eligible ❑ Denied

Entered to Database: _____ Letter Sent: _____ Appeal Date: _____

Eligibility Period: ❑ 3 years ❑ 1 year ❑ Visitor ❑ Temporary to _____

PCA Confirmed by: _____ Date: _____

Comments: _____