LONGVIEW TRANSIT CERTIFICATION OF ADA ELIGIBILITY

OFFICE USE ONLY

Determination: _____

Expiration Date: _____

In-Person Interview Date: _____

Date Received: _____

Return completed application to:

LONGVIEW TRANSIT
Attention: Paratransit Coordinator
908 E. Pacific Ave.
Longview, Texas 75602
Fax#: (903) 753-2291
tmumphrey@longviewtransit.com

LONGVIEW TRANSIT will only use the information obtained in this certification process for the provision of transportation services.

PART I -- To Be Completed By Applicant *(Please Print or Type)*

Last Name	First Name	Middle Initial
Street Address		Apartment Name/No.
City	State	Zip Code
Home Phone	Work Phone	Date of Birth

****

PART II – Please answer all of the following questions.

1. Are you able to board and disembark without assistance from Longview Transit staff or a wheelchair lift?
   Yes____ No____ If no, please explain:_____

2. Are you able to board and disembark without assistance from Longview Transit *with* a wheelchair lift?
   Yes____ No____ If no, please explain:_____

3. Are you able to travel to the nearest bus stop?
   Yes____ No____ If no, please explain:_____
   Location:_____ How Far:_____

4. Do you currently use Longview Transit services?
   Yes____ No____
   What routes?_____

5. Are you able to handle money and transfers?
Yes____ No____ If no, please explain:_____
_____

6. And are you able to use railings and handles?
Yes____ No____ If no, please explain:_____
_____

7. Are you able to keep balance while seated on a moving bus?
Yes____ No____

8. Are you able to understand bus schedules? Yes____ No____
Understand and follow directions? Yes____ No____
Process information to ride Longview Transit? Yes____ No____

9. If you can use a lift-equipped bus, are you presently unable to ride because:
____One of more routes you want to ride do not have lift-equipped buses?
____The lift cannot be operated at bus stops where you need to board?
____Your wheelchair cannot be accommodated on a transit vehicle?
____Other reasons. Please explain: _____
_____
_____

10. Are you prevented from traveling to or from a bus stop boarding location for one or more of the following reasons?
____Inability to negotiate hilly terrain
____Extreme sensitivity to climatic conditions
____Allergic/environmental sensitivities
____Hyper-fatigue, frailty
____Night blindness
____Inability to cross busy intersections
____Inability to climb three 10-inch steps
____Bus stop too far away
____Other reasons. Please explain:_____
_____

11. Are you able to perform the following functions without supervision?

a) Find your way between familiar locations?
Yes____ No____ Yes, with training ____

b) Signal the bus driver to get off at a familiar stop and get off the bus there?
Yes____ No____ Yes, with training ____

c) At a bus stop served by more than one bus route, can you distinguish the correct bus to board and indicate your intention to board?
Yes____ No____ Yes, with training ____

12. Are you able to perform the following functions without the assistance of another person?
    ____Travel 200 feet (the length of a city block)
    ____Travel ¼ mile (the length of 3 city blocks)
    ____What is the maximum distance you can travel to get to a bus stop?

13. Is your ability to get from place to place affected by:
    ____Terrain, such as steep hills, no sidewalks/crosswalks, or other conditions
    ____Rain, snow, ice
    ____Extreme temperatures of heat or very cold, windy weather

14. Are you able to wait outdoors for 10 minutes?
    Yes____ No____ Sometimes____
    If no, please explain_____
    _____

15. Do you have trouble standing for more than 15 minutes?
    Yes____ No____ Sometimes____
    If yes, please explain_____
    _____

16. Does your disability allow you to use the bus when you are feeling well?
    Yes____ No____

17. Does your disability allow you to use the bus when you are *not* feeling well?
    Yes____ No____

18. Are there sidewalks at your residence?
    Yes____ No____

19. How would you describe the terrain where you live? (very steep hill, long gradual hill, flat, etc.) _____
    _____

20. Are you able to cross the street or a busy intersection by yourself?
    Yes____ No____ If yes, under what conditions _____
    _____

21. Longview Transit provides free travel training on fixed route. Would you be interested in learning to ride independently by participating in travel training? Yes____ No____

22. List three of your most frequent destinations, and how you get there?

Destination or Street Address	Frequency of Travel	How do you get there now?
_____	_____	_____
_____	_____	_____
_____	_____	_____

23. Are there places you would like to go that you *cannot* get to now?

Destination or Street Address	Frequency of Travel	Barriers?
_____	_____	_____
_____	_____	_____
_____	_____	_____

24. How did you find out about the LONGVIEW TRANSIT service?

_____

_____

PART III – Please answer all of the following questions.

The following information will be used to ensure that an appropriate vehicle is sent to provide transportation and that LONGVIEW TRANSIT can make an accurate analysis of the applicant's trip requests.

Does the applicant use any of the following mobility aids? (Check all that apply)

☐ Cane	☐ Power Chair	☐ Communication Board
☐ White Cane	☐ Large Power Chair	☐ Service Animal
☐ Walker	☐ Power Scooter *	☐ Portable Oxygen Supply
☐ Crutches	☐ Manual Chair	☐ Personal Care Attendant
☐ Leg Braces	☐ Picture/Alphabet Board	☐ Other: _____

PART IV – Please select someone who would NOT be riding with you.

In Case Of Emergency Notify:

_____

Name Relationship

_____

Home Phone Work Phone

_____

Address City State Zip Code

****

PART VI – Please initial each box.

I understand the following rights and responsibilities;

1. LONGVIEW TRANSIT is public transportation and I will be sharing rides with other passengers…….…… ☐
2. LONGVIEW TRANSIT does not provide same day or emergency 911 services. .....…….…….. ☐
3. I must show my LONGVIEW TRANSIT ID card, and have the correct fare ready each time I ride (LTMI drivers does not provide change) ……..... ☐
4. Patterns of "No Shows" will result in ridership suspensions.…… ☐
5. LONGVIEW TRANSIT has (15) minutes before and (15) minutes after the scheduled pick up time to arrive……..... ☐
6. LONGVIEW TRANSIT will wait only (5) minutes from the time it arrives……. ☐
7. LONGVIEW TRANSIT will provide reasonable accommodation to customers. If you need reasonable accommodation, notify the dispatch when scheduling your trip. .....…….…… ☐

I certify that the information provided in this application is accurate. I understand that false information may result in the denial or annulment of LONGVIEW TRANSIT service. I further understand that all information will be kept confidential, and only the information required to provide the services I request will be disclosed to those who perform those services.

Applicant's Signature _____ Date _____

Interviewer's Signature _____ Date _____

**If applicant has been assisted by someone else in completing this application, that person must complete the following:

Last Name	First Name	Middle Initial
Street Address		Apt. No.
City	State	Zip Code
Home Phone	Work Phone	Relation to Applicant

****

Office Use Only

Screening Committee Review:
Reviewed By: _____ Date:_____ Decision:_____

Reviewed By: _____ Date:_____ Decision:_____

Demographics:

Age_____Race_____Gender_____Nationality_____

Comments: _____

_____

_____

_____

_____

_____

_____

Dear Health Care Provider:

The Americans with Disabilities Act and its implementing federal regulations established categories of persons who are eligible to receive paratransit services complementary to fixed-route bus services. The three categories of persons with rights to complementary paratransit are:

1. Persons, who, because of their disability, cannot independently board, ride and/or disembark from an accessible vehicle.

2. Applicants who can use or learn to use an accessible public transit system, but the system is not fully accessible.

3. Persons who, because of their disability, cannot get to or from a boarding or disembarking location.

Any individual is to be certified as ADA paratransit eligible if there is any part of the transit system that cannot be used or navigated by that individual because of a disability. Persons are not to be qualified or disqualified on the basis of a specific diagnosis or disability.

The information requested from you on the following pages will allow LONGVIEW TRANSIT to obtain the information necessary to establish eligibility of the applicant.

Thank you for your assistance.

PART VI -- To Be Completed By Appropriate Health Care Provider
(Please Print or Type)

Please Check One:
___ Physician
___ Licensed Health Care Provider
___ Licensed Rehab/Social Worker
___ Other _____

Applicant's Name _____
Last First Mid. Initial

Medical diagnosis of condition causing disability:_____
_____
_____

Is the condition permanent?

Yes____ No____ If not, expected duration:_____

Does this disability prevent the applicant from utilizing the fixed route services (regular bus service)? If yes, please describe in detail. _____
_____
_____
_____

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PART VII – Please answer all of the following questions.

The following information will be used to ensure that an appropriate vehicle is sent to provide transportation and that LONGVIEW TRANSIT can make an accurate analysis of the applicant's trip requests.

Does the applicant use any of the following mobility aids? (Check all that apply)

___ Cane	___ Power Chair	___ Communication Board
___ White Cane	___ Large Power Chair	___ Service Animal
___ Walker	___ Power Scooter *	___ Portable Oxygen Supply
___ Crutches	___ Manual Chair	___ Personal Care Attendant
___ Leg Braces	___ Picture/Alphabet Board	___ Other: _____

Scooter
Model_____Make_____Weight/Dimensions_____
* If a power scooter is used, please provide model, weight, and dimensions specific to the client's scooter. Mobility devices that exceed the recommended lift weight limit will not be allowed on the lift. To reduce the weight customers may board separately from their mobility device.

Applicant height: _____

Applicant weight: _____

Can the applicant walk or wheel ¼ mile (2 blocks) without the assistance of another person?
Yes____ No____

1. Can the applicant climb three 10-inch steps with assistance?
   Yes____ No____

2. Can the applicant wait outside without support for 15 minutes?
   Yes____ No____

3. Is applicant on dialysis?
   Yes____ No____

4. Does the applicant have a hearing impairment?
   Yes____ No____

5. Is the applicant able to give addresses and phone numbers upon request?
   Yes____ No____

6. Is the applicant able to recognize a destination or landmark?
   Yes____ No____

7. Is the applicant able to deal with unexpected situations or unexpected changes in routine?
   Yes____ No____

8. Is the applicant able to ask for, understand, and follow directions?
   Yes____ No____

9. Is the applicant able to safely and effectively travel alone through crowded and/or complex facilities?
   Yes____ No____

**** If the applicant has a visual or hearing impairment:**

Longview transit has ADA Call Announcements on all buses to help assist the visual and hearing impaired with locations on the route.

Visual acuity with best correction: Right Eye _____ Left Eye _____
Both Eyes _____

Visual Fields: Right Eye _____ Left Eye _____
Both Eyes _____

Please describe any other disability or effect that prevents the applicant from using the regular bus service. _____
_____
_____
_____

PART VIII

Based upon my professional knowledge of the applicant, I certify that the preceding information is true and correct.

_____
Name of Health Care Provider (Please Print) Office Phone Number

_____
Office Street Address City State Zip Code

_____
State License Number (Complete if Applicable – Must be Current)

Signature _____ Date _____