Piedmont Area Regional Transit's (PART) ADA Application

Thank you for inquiring about the PART "ADA" service. The primary mode of public transportation for everyone is considered to be PART (regular bus). However under a federal law called the American's with Disabilities Act or "ADA", service is to be provided to those individuals who are "functionally" unable to use PART some or all of the time, due to a disability and live within a ¾ mile distance of the fixed route. The information you provide in this application will help us determine whether you are eligible for "ADA service" based on the criteria outlined in the ADA law.

Eligibility is based on your current functional ability to ride PART buses. It is not based on your age, trip purpose, financial resources, ability to drive, name of your disability/medical diagnosis, or having no bus service where you live. ADA eligibility is a transportation decision, not a medical one. If there are any conditions of eligibility, they will be listed and explained in your determination letter.

If you are already certified for an "ADA" service in another city, please call our office at 800-964-5707 before completing this application and provide us with your current "ADA" service information to acquire a certification number.

The following steps are required to complete the ADA application process:

STEP 1: FILLING OUT YOUR APPLICATION

It is important that this application be filled-out thoroughly with current information about your functional abilities and any conditions that limit your use of PART buses. You may complete the application yourself or have someone else help you with it. If someone else is filling out the application for you, have them sign their name in the appropriate section. Once the application is complete, please be sure to review all pages for accuracy and please remember to also sign your name. Incomplete applications will be returned to the applicant and will delay eligibility determination.

STEP 2: PROFESSIONAL VERIFICATION

After your application has been completed, it is important that you have a professional(s) who is familiar with your particular disability and current ability to use PART buses verify the information that you have provided. The professional verification should be someone other than the person filling out this form. The professional verification section must be completed before submitting your application.

Some examples of professionals you could use would be:

*physician or registered nurse
*occupational therapist
*psychiatrist, psychologist, or mental health counselor
*independent living skills trainer
*special education teacher
*mobility instructor or travel trainer

STEP 3: AWAITING YOUR DETERMINATION

After you have done all that is required to complete the application process, your information will be reviewed and you will be notified by mail of your eligibility determination within 21 days. It is not necessary to contact our office while your application is being processed. You will also be notified if any additional information is needed or if any further action is required on your part.

STEP 4: GUIDELINES FOR USING THE SERVICE

The "ADA" service area is the City of Martinsville and the County of Henry. Hours of operation are Monday – Friday, 6:00 a.m. to 6:00 p.m. The "ADA" service is closed on New Year's Day, Good Friday, July 4th, Thanksgiving Day, Memorial Day, Labor Day and Christmas Day.

The amount of a one-way "ADA" trip is **$1.00**. Drivers are not allowed to make change and only accept cash. Fares are collected before the client boards the vehicle.

All passengers must be "ADA" Eligible prior to scheduling service. Reservations are taken Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m. by calling 800-964-5707, extension 3. Reservations must be made on the day before the trip is to be taken and can be made up to fourteen (14) days in advance of needed time. When scheduling your appointment the following information will be needed:

a. Certification number
b. Desired pickup time, pickup location, etc. (oversized wheelchairs, personal care attendant traveling)

The bus will be scheduled as per your request and will wait only 5 minutes past your scheduled time. In an effort to make scheduling more efficient, PART has the right to adjust the pickup time within one hour before or after the desired scheduled appointment. Individuals that miss a scheduled pickup time should call **800-964-5707** to arrange another pickup time. **Please be aware that if you miss the bus, you will have to wait until the next scheduled stop is made.**

Passengers are allowed to bring along a personal care attendant free of charge as long as the attendant is not certified under this program. The reservationist must be notified that a personal care attendant will be accompanying the passenger during travel when setting up the passenger's travel arrangements.

Cancellations of trips must be made at least one hour in advance of the trip. Repeated no shows (un-cancelled trips) can result in suspension of service.

"ADA" service provided is origin to destination. Drivers will assist passengers when boarding and un-boarding the vehicle. At no time may a driver enter a building.

Please return your completed application to PART ADA Service, RADAR, P. O. Box 13825, Roanoke, Virginia 24037. If you have any questions, please call 800-964-5707.

You may also visit our website at www.radartransit.org for information regarding the PART service.

SECTION A: GENERAL INFORMATION **Cert. No.**_____

Full Name: _____

Address: _____

City, State, Zip:
_____

Mailing Address (if different than above):_____
_____

Daytime Phone: _____ Evening Phone:
_____

Date of Birth :_____(optional) Male Female

In case of an emergency, whom may we contact? (Please select someone who would not be riding with you).

Name: _____ Relationship: _____

Address: _____

City, State, Zip: _____

Daytime Phone: _____ Evening Phone: _____

Please describe the disability or health condition that prevents you from using fixed route buses (PART). Please list all disabilities or health conditions that apply.
_____
_____
_____
_____

Is this disability or health condition temporary? _____Yes _____ No

If yes, how long do you expect it to prevent you from using fixed route buses?
_____ Months

Do you ever need to bring someone with you when you travel (a personal care attendant)?
Yes, always Yes, sometimes No

How do you currently travel to your most frequent destinations?
Bus Drive Myself Taxi Someone drives me

SECTION B: ABILITIES TO RIDE FIXED ROUTE BUSES

Please read the following statements and check those which best describe your abilities to use fixed route buses. (Check all that apply).

Fixed route buses means the city buses operated on set routes by PART.

I can get to and from bus stops if the distance is not too great.

I can ride the bus when I am feeling well. There are other times, however, when my disability or health condition worsens, and at these times I cannot ride the buses.

I have a disability or health condition which prevents me from riding the buses or trains if the weather is very hot or very cold.

My disability or health condition makes it impossible to travel when there is snow or ice on the ground.

I am not really sure if I can use fixed route buses.

I can never use fixed route buses by myself.

I can use fixed route buses if it's someplace I go all the time.

I cannot climb stairs to get on and off fixed route buses.

I am not able to use fixed route buses because I have difficulty understanding how the bus routes/system works.

I am not able to use fixed route buses for other reasons. Please explain:

_____
_____
_____
_____
_____
_____

Have you ever had training to learn how to travel around the community or on how to use fixed route buses?

Yes No

Would you like information about free training to use the fixed route buses?

Yes No

When was the last time you used fixed route buses? _____

If you used fixed route buses in the past and have stopped using them, why did you stop?

_____
_____
_____

List the three (3) places you go most often and how you get there now.
Where do you go? _____
Address_____
How do you get there now? _____

Where do you go? _____
Address_____
How do you get there now? _____

Where do you go? _____
Address_____
How do you get there now? _____

SECTION C: FUNCTIONAL ABILITIES

Do you use any of the following mobility aids or specialized equipment?

Cane	Portable Oxygen
Crutches	Powered Wheelchair
Walker	Manual Wheelchair
Service Animal	Long White Cane
Power Scooter	Oversized Wheelchair
Leg Braces	Prosthesis
Other, Specify_____	

WITHOUT THE HELP OF SOMEONE ELSE, CAN YOU…

Ask for and understand written or spoken instructions?
Always Sometimes Never Not Sure

Cross the street?
Always Sometimes Never Not Sure

Stand for 10 minutes if there is no place to sit?
Always Sometimes Never Not Sure

Step on and off a sidewalk from the curb?
Always Sometimes Never Not Sure

Walk up and down three (3) twelve (12) inch steps?
Always Sometimes Never Not Sure

Stand on a moving bus holding onto a handrail?
Always Sometimes Never Not Sure

Find your own way to the bus stop if someone shows you once?
Always Sometimes Never Not Sure

<u>WITHOUT</u> THE HELP OF SOMEONE ELSE, CAN YOU… (CONTINUED)

Transfer from one fixed route bus to another bus?

Always Sometimes Never Not Sure

Walk up and down three (3) twelve (12) inch steps with handrail?

Always Sometimes Never Not Sure

Under the best of conditions, what is the FARTHEST you can walk outdoors (or travel using your mobility aid) without the help of another person?

Less than 1 block
1 block
2 blocks (1/4 mile)
6 blocks (3/4 mile)
More than 6 blocks
4 blocks (1/2 mile)
I cannot travel outdoors alone at all.

Is there anything else you want to tell us about your disability or health condition that might help us better understand your travel abilities and limitations?

SECTION D: PROFESSIONAL ASSESSMENT

This section of your application must be completed, signed and dated by a professional who is familiar with your disability or health condition. Information obtained is confidential and will be used to determine if you have the functional ability to use PART fixed route service. Please use common language and print or type clearly.

Can the applicant use public fixed route service?
Yes No

Specify how the applicant's disability or health condition affects his/her ability to use public fixed route service?

_____
_____
_____
_____

Is the applicant's disability or health condition permanent or temporary?
Permanent Temporary

If temporary, how long will services be needed? _____

Please indicate the applicant's ability to perform the following functions:

Understand directions needed to complete a trip?	Yes	No
Identify the correct bus stop?	Yes	No
Travel independently to and from nearest transit stop?	Yes	No
Wait standing 15 minutes at a stop?	Yes	No
Wait if seated?	Yes	No
Get on/off a bus without assistance?	Yes	No
Get on/off if a kneeling device/lift is deployed?	Yes	No
Can the applicant benefit from travel training?	Yes	No
Walk 200 feet without assistance?	Yes	No
Walk 1/4 mile without assistance?	Yes	No
Walk 3/4 mile without assistance?	Yes	No
Safely and effectively travel through crowded areas?	Yes	No
Does applicant use any mobility aids?	Yes	No

If so, what type? _____

The applicant's disability or health condition is currently:
Under Control Not Under Control Improving

Is there anything else you want to tell us about the applicant's disability or health information that might help us better understand the applicant's travel abilities and limitations?

_____

_____

_____

_____

_____

PROFESSIONAL VERIFICATION

I understand that the purpose of this application is to determine if the applicant is eligible to use "ADA" Services. I certify that the information provided in this application is true and correct. I understand the falsification of the information may result in denial of service to the applicant. I understand that all information will be kept confidential.

Professional's Signature:_____

Print Name: _____

Title: _____ Date: _____

Organization: _____

APPLICANT'S SIGNATURE

I certify that the information in this application is true and correct and I understand that giving false or misleading information may result in denial of "ADA" Services. I understand that all information will be confidential to the extent possible, and used to determine my eligibility for "ADA" services.

Applicant's Signature: _____

Date: _____ (If unable to sign, please see below)

NOTE: If only able to make a "mark" for your signature, simply make your mark and then have someone act as a witness by signing their name above or beside yours.

IF SOMEONE ELSE HAS FILLED-OUT THIS APPLICATION FOR YOU PLEASE HAVE THEM COMPLETE THE FOLLOWING:

The information provided in this application is based upon:

Information given to me by the applicant.

My own knowledge of the applicant's current disability and health condition.

Signature: _____ Date: _____

Relationship to Applicant: _____

Daytime Telephone Number: _____

THANK YOU FOR TAKING THE TIME TO FAMILIARIZE YOURSELF WITH THE INFORMATION IN THIS PACKET. IF YOU HAVE ANY FURTHER QUESTIONS ABOUT OUR "ADA" SERVICE YOU MAY CALL 800-964-5707 Ext. 105.
WE LOOK FORWARD TO SERVING YOU.

For Internal Use Only:

ADA ELIGIBLE YES NO

RESIDENCE OF: MARTINSVILLE CITY COUNTY OF HENRY

CERTIFICATION DATE: _____

EXPIRATION DATE: _____

CERTIFIED BY: _____