ADA Paratransit / Special Transportation Eligibility Application Form

Please Read Carefully!

Any unsigned or incomplete applications will not be processed. Staff may consult with appropriate professional experts regarding your eligibility at any stage of the certification process. Submission of this application does not guarantee eligibility. A decision about your eligibility will be communicated by the applicant's preferred contact method.

Upon completion of this application, please have it returned the following address:

City of Corvallis Public Works
Attention: Transit Eligibility
Post Office Box 1083
Corvallis, OR 97339

If you have questions or need help with the application, please call our **Eligibility Line** at **541-766-6318** or visit: **www.RideTheBAT.com** or **www.corvallisoregon.gov/cts**

1. Affirmation of True and Accurate Information

I swear or affirm that the information provided in this application is true and correct. I understand that deliberately providing false information will disqualify my application. I further understand and authorize that the information provided in this application will remain confidential and is to be used by Benton Area Transit Lift (BAT Lift) and/or Corvallis Transit System (CTS), its agents and employees, for the express purpose of determining eligibility and providing specialized transportation services. Additionally, I understand that if deemed eligible, I must adhere to the ridership rules, policies, and procedures of the respective agency and said agencies hold the right to suspend/cancel my eligibility at any time for cause.

Applicant/Legal Guardian's Signature:	**Date:**

NOTE: If applicant is unable to sign and there is no assigned legal guardian, both signatures below are required:

Signature of Person Completing Form:	**Date:**
Signature of Witness, Relationship to Applicant:	**Date:**

2. Applicant Information:

Applicant Name (Last, First):		**Date of Birth:**	
Primary Address (include Apt #):	**City:**	**County:**	**Zip:**
Billing Address, if different:	**City:**	**County:**	**Zip:**
Primary Phone Number:	**Secondary Phone Number, if applicable:**		
Email Address:	**Preferred Contact Method:** ☐ By Phone ☐ By Mail ☐ By Email ☐ Applicant's Representative		
Do you utilize Medicaid or Oregon Health Plan (OHP)? ☐ Yes ☐ No ☐ Unsure			

3. Emergency Contact Information:

Emergency Contact Person (Last, First):	**Relationship to Applicant:**
Primary Phone Number:	**Secondary Phone Number, if applicable:**

4. Applicant Representative Information:

If someone other than the applicant is filling out this form and/or submitting this application on the applicant's behalf, please fill out Section 4, below:

Name of Representative (Last, First):		**Relationship to Applicant:**	
Primary Address (include Apt #):	**City:**	**County:**	**Zip:**
Billing Address, if different:	**City:**	**County:**	**Zip:**
Primary Phone Number:	**Secondary Phone Number, if applicable:**		
Email Address:	**Preferred Contact Method:** ☐ By Phone ☐ By Mail ☐ By Email		

For applicants <u>65 and older:</u> If you have a disability that you wish to describe to see if you are eligible for ADA paratransit, continue to Section 5. Otherwise, STOP HERE.

5. Disability Information:

Are you or have you previously been certified by either of the following transit agencies?

- ☐ Corvallis Transit System (CTS) – ADA Paratransit
- ☐ Benton Area Transit (BAT) – BAT Lift
- ☐ No

Do you have a disability and/or health-related condition that prevents you from using private transportation or general public transit? ☐ Yes ☐ No

<u>If yes</u>, please completely fill out Sections 5, 6, and 7 of this application. Use an additional sheet of paper if needed. You may attach supporting documents that describe your disability if you wish. <u>*Vague or incomplete information will delay the processing of your application.*</u>

If applicable, please describe how your disability prevents you getting to/from a CTS, PC, or BAT general public transit bus stop:

_____

_____

If applicable, please describe how your disability prevents you from boarding a general public transit bus:_____

_____

If applicable, please describe how your disability prevents you from navigating the general public transit system:_____

_____

If applicable, please describe how your disability prevents you from transferring between general public transit buses and systems:_____

_____

Is your condition: ☐ Permanent ☐ Temporary

If your condition is temporary, how long do you expect it to last (insert day/month/year)?

/ /

Given your condition(s), how do you currently travel? (Check all that apply.)

- ☐ Transit ☐ Private Vehicle ☐ Someone Drives me
- ☐ Bicycle/Walk/Mobility Device ☐ Other, explain:_____

6. Mobility Device Information:

Do you require a PCA when you a travel? (A Personal Care Attendant, "PCA," is someone whose help you require for daily activities such as eating, dressing, personal hygiene, carrying packages, navigating, etc. PCAs are not provided by BAT or CTS).

☐ Yes ☐ No ☐ Sometimes

If Sometimes, please briefly explain:_____

_____

_____

Are you able to get from your home to the curb without help from another person?

☐ Yes ☐ No

Do you use a mobility aid?

☐ Walker/Cane/Crutches/Orthotic Device ☐ Wheelchair/scooter

☐ Prosthetic Device ☐ Service Animal ☐ None ☐ Other:_____

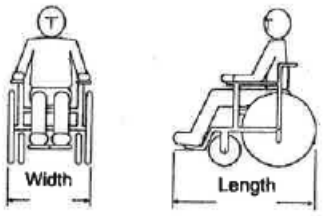
If you use a wheelchair/scooter, is the combined weight between you and your mobility aid over 600 pounds?

☐ Yes ☐ No

What are the dimensions of your wheelchair/scooter?

Width _____ inches

Length _____ inches



About how far can you travel *USING* your usual mobility aid(s) and without the help of another person? _____

_____

7. Release of Medical Information – Authorization

In order for your application to be properly reviewed, it may be necessary to contact a physician or other medical professional, either to confirm the information you have provided, or to address a functional question regarding your disability as it relates to the manner in which we provide safe and effective transportation services.

Please fill out the information below regarding whom to contact if verification of information or a practical question requiring healthcare expertise is required. This professional may be your primary care physician, other health care professional, or rehabilitation professional familiar with your disability.

<table>
<tr><td colspan="4">This contact is a:
☐ Physician ☐ Rehabilitation Professional ☐ Clinic ☐ Other Healthcare Professional</td></tr>
<tr><td colspan="4">Name of Contact (Last, First, Prefix):</td></tr>
<tr><td colspan="2">Primary Address:</td><td>City:</td><td>County: Zip:</td></tr>
<tr><td>Primary Phone Number:</td><td colspan="3">Fax Number:</td></tr>
</table>

NOTE: Refusal to authorize this release of information may result in denial of certification if eligibility cannot be determined otherwise.

Print your name:	**Date of Birth:**
Applicant or Legal Guardian Signature:	**Date:**

- End of Application -