



Effective 10-1-09



Thank you for your interest in SARTA “Shared Ride” Paratransit Transportation Services.

**Purpose of Paratransit**

Our program requires that you are not able to access our Fixed Route bus service. You will be asked to complete a written application with physician certification and/or followed by an in-person functional assessment. If through the written application and physician verification, it is deemed you are able to access our Fixed Route bus service, you will not be eligible for our ADA Paratransit service.

SARTA provides Paratransit services on buses to persons who cannot use the regular bus system. To be eligible for this service, individuals must have disabilities that prevent the use or access of the regular bus system. Eligibility is based on whether your disability prevents you from performing the tasks needed to ride regular bus service some or all of the time. Age, income, access nor distances to the nearest bus stop by themselves, are not eligible disabilities.

Transit agencies such as SARTA must take specific steps to make regular bus service accessible to persons with disabilities. Regular accessible bus service is intended to be the primary mode of public transportation for persons with disabilities.

The ADA also requires Paratransit service as a ‘safety net’ for persons whose disabilities prevent use of accessible non-commuter, Fixed Route bus service. The federal government adopted minimum criteria that transit agencies must meet in operating this complementary Paratransit service. Complementary Paratransit service is intended to offer a comparable level of service provided by regular bus service. Paratransit service is not required, nor intended, to meet all the transportation needs of persons with disabilities. Rather, it is intended to provide public transportation in a more specialized form.

SARTA’s ADA Paratransit Program is designed to meet the minimum service criteria established by the federal government. This certification form will be used to determine your eligibility for SARTA’s ADA Paratransit Service.

**WHAT IS “SHARED RIDE” SERVICE?** SARTA Proline “Shared Ride” service is for those who cannot access the Fixed Routes due to a disability. Passengers usually ride with others who are traveling in the same general direction, and drivers may stop to pick up or drop off passengers on route. We cannot go inside your house to get you, and we do not take you inside your destination. We provide transportation service only.

This service is a “safety net”; it is **only** for those persons who do not have the **functional** capability to ride the Fixed Route buses.

The Americans with Disabilities Act (ADA) guarantees people with disabilities the same access to public transportation as people without disabilities. Many people with disabilities can ride the regular Fixed Route buses. People with disabilities who cannot use the Fixed Route buses can use the ADA Paratransit Service.

**You must complete the entire form and answer every question. Incomplete forms will be returned.** A **physician** must verify your disability, prognosis and date of occurrence(s). Verification can be obtained directly from your physician. This information must be submitted with the application and on the enclosed form. The information you provide is confidential. It will only be shared with persons involved with SARTA’s eligibility determination process and other transit providers to facilitate travel in those areas, and will not be provided to any other person or agency.

SARTA will respond to your completed application within 21 days. Each applicant will be notified of the eligibility determination no later than 21 days after SARTA has received the completed application, including the medical assessment.

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**If you have any questions or need assistance completing this form, please call:**

**330-455-2292 (Phone)      1-800-379-3661 (Toll Free)**  
**330-458-1053 (Fax)      1-800-750-0750 (TTY Ohio Relay Service)**

**WHEN COMPLETED, PLEASE RETURN THIS FORM TO:**

Stark Area Regional Transit Authority  
ADA Paratransit Services  
1600 Gateway Blvd., SE  
Canton, OH 44707

**General Information to be Completed by Applicant**  
**(Please print or type)**

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Last Name	First Name	Middle Initial
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Male/Female	Date of Birth
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Street Address

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Apartment Name	Building No./Apt. No.
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City/Town	State	Zip
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Home Phone	Work Phone	Cell Phone
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Emergency Contact Name	Emergency Phone
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If you have a current SARTA ADA Paratransit Code number, please provide the number:  
# \_\_\_\_\_

**Applicant's Release**

I understand the purpose of this evaluation form is to determine my eligibility for Paratransit Service. I understand the information about my disability contained in this application will be kept confidential and shared only with professionals involved in evaluating my eligibility.

I hereby authorize my medical representative to release any and all information regarding my medical condition to SARTA.

I understand that providing false or misleading information could result in my eligibility status being revoked.

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<b>Applicant's Signature</b>	<b>Date</b>
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If applicant is unable to sign this form, he/she may have someone sign on his/her behalf.

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<b>Signer for the Applicant</b>	<b>Relationship</b>	<b>Date</b>
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Please read the following statements and check those that best describe what you believe to be your ability to use SARTA's Fixed Route bus services without assistance. You may select more than one.

When are you unable to independently use SARTA's Fixed Route bus services?

- I can use SARTA Fixed Route bus services for some trips, but not other times because there are barriers that prevent me from using the system.
- I use the bus frequently.
- I have difficulty understanding and remembering all of the things that I would have to do to find my way to and from the bus.
- I believe I could learn to ride the bus, if I were taught.
- I have difficulty or cannot climb stairs and can only board a SARTA vehicle if it has a lift.
- I have a visual disability, which prevents me from getting to and from the bus, even with training.
- The severity of my disability can change from day-to-day. I can only ride the Fixed Route bus when I am feeling well.
- I can never use the bus by myself.
- I can get to and from the bus if the distance is not too great and the route is barrier-free.
- I am not able to use the bus due to my disability. (Please explain in detail your disability that prevents you from using SARTA's Fixed Route bus service.)

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**YOUR CURRENT TRAVEL**

Please List your 3-4 most frequent destinations and how you get there now.

Destination addresses      Frequency of travel      How you get there?

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1. Does your health condition/disability require you to use Paratransit Service:  
 Seasonal (Nov. - Apr.)  
 Permanently  Temporarily  
 If temporarily, for how long?  Week(s)  Month(s)  Year(s)

2. Please indicate the primary mobility aid you use when traveling in the community:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Support Cane    | <input type="checkbox"/> Leg Brace      | <input type="checkbox"/> Picture Board      |
| <input type="checkbox"/> Long White Cane | <input type="checkbox"/> Crutches       | <input type="checkbox"/> Alphabet Board     |
| <input type="checkbox"/> Service Animal  | <input type="checkbox"/> Walker         | <input type="checkbox"/> Powered Wheelchair |
| <input type="checkbox"/> Hearing Aid     | <input type="checkbox"/> Prosthesis     | <input type="checkbox"/> Manual Wheelchair  |
| <input type="checkbox"/> Oxygen Tank     | <input type="checkbox"/> Hearing Device | <input type="checkbox"/> Scooter            |
| <input type="checkbox"/> Other _____     |   |   |

**Note: SARTA may not be able to accommodate you if your wheelchair or scooter is longer than 48" or wider than 30" or if your total weight with your wheelchair is more than 600 pounds.**

3. Have you ever had a seizure?

- Yes  No

If yes, what type? \_\_\_\_\_ How often? \_\_\_\_\_

Are your seizures controlled with medication?

- Yes  No

4. Do you require a Personal Care Attendant (PCA)? A PCA is a person who will assist you to and from the bus because SARTA's Proline service is curb-to-curb only.

- Yes  No

5. Are you able to be left unattended?

- Yes  No

**QUESTIONS ON USING THE BUS**

1. Have you ever used SARTA's bus services?

- Yes  
 No

2. Does your physical condition change from day-to-day, to the point that it may be difficult to use bus services?

- Yes, my physical condition is good some days and bad others.  
 No, my physical condition does not change from day-to-day.  
 Not sure  
 Other reasons \_\_\_\_\_

3. On days when your physical condition is **good**, can you, on your own, or using a mobility aid:

- Get to the curb in front of your house
- Travel up to one (1) block
- Travel up to four (4) blocks
- Travel up to six (6) blocks
- Cannot travel outside your house. Please explain:

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4. On days when your physical condition is **bad**, can you, on your own, or using a mobility aid:

- Get to the curb in the front of your house
- Travel up to one (1) block
- Travel up to four (4) blocks
- Travel up to six (6) blocks
- Cannot travel outside your house. Please explain:

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5. Does the weather have an effect on your ability to use bus services?

- Yes
- No

6. Are you currently using SARTA's bus services?

- Yes
- No

If yes, what routes: \_\_\_\_\_

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7. Can you transfer from one bus to another?

- Yes
- No, please explain:

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8. Are you able to, on your own, use the telephone to obtain bus information?

- Yes
- No, please explain:

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9. Are you able to follow written or oral instructions to use bus services?

Yes

No, please explain:

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10. Can you, without the assistance of another person, get to or from the bus stop nearest your home?

Yes

Not sure

No, please explain:

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11. Can you wait ten (10) minutes at a bus stop that has a seat and a shelter?

Yes

Not sure

No, please explain:

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12. Can you wait ten (10) minutes at a bus stop that does not have a seat and a shelter?

Yes

Not sure

No, please explain:

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13. Are you able to get on and off a bus if it had a mobility device lift?

Yes

Not sure

No, please explain:

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14. Are you able to follow written/oral instructions to pay your bus fare?

Yes

No, please explain

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15. Are you able to recognize a destination or landmark?

Yes

Not sure

No, please explain:

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16. Can you cross a street?

Yes

No, please explain:

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17. Can you balance while seated?

Yes

No, please explain:

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18. Can you grip handles and railing?

Yes

No, please explain:

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19. Can you climb a 12-inch step?

Yes

No, please explain:

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**MEDICAL VERIFICATION**  
**(TO BE COMPLETED BY A LICENSED PHYSICIAN)**

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

The person named above is \_\_\_\_ currently being treated or \_\_\_\_ was formerly treated by me. The person has informed me of his/her intent to apply for SARTA's Proline Service. The information provided in this form is intended to verify any medical/health conditions that prevent the applicant from using SARTA's Fixed Bus Route services.

1. Please indicate nature of applicant's disability (**check all that apply**)

- Impaired or assisted ambulation: Specify mobility aid: \_\_\_\_\_
- Arthritis: Specify extremity: \_\_\_\_\_
- Cerebral Vascular Accident (Stroke)
- Pulmonary: Does applicant travel with Portable Oxygen Tank?  Yes  No
- Neurological Handicap  Cardiac  Kidney Disease
- Legally Blind  Severely Visually Impaired  Alzheimer's
- Dementia  Mental Retardation (indicate one)  Cerebral Palsy
- Autism  Moderate  Severe  Profound
- Deaf/Hard of Hearing: Specify nature of: \_\_\_\_\_
- Seizures  Mental Illness  Other \_\_\_\_\_

2. Please describe all conditions and severity (physical, cognitive, emotional, other), which functionally prevents the applicant from using SARTA's Fixed Route lift equipped buses.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. How does this condition prevent the applicant from using SARTA's lift equipment fixed route bus service?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**This section must be completed for application to be considered complete.**

I certify that the information contained in this application is true and correct to the best of my knowledge and ability.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

Professional Title \_\_\_\_\_

State of Ohio License No. \_\_\_\_\_

Clinic/Agency \_\_\_\_\_

Address \_\_\_\_\_

I, \_\_\_\_\_ hereby verify that the diagnosis of disability listed above has been reviewed by me, is accurate and true, and represents the current physical and/or mental condition of the applicant named on this form.