Proline ADA Paratransit Application

Purpose of Paratransit

Transit agencies, such as SARTA, take steps to make fixed route bus services accessible to persons with disabilities. Fixed route bus service is intended to be the primary mode of public transportation for persons with disabilities.

The Americans with Disabilities Act (ADA) requires that complementary ADA Paratransit Service be provided, as an alternative transportation, for qualified persons who are unable, because of disability, to use a fixed route system. ADA regulations requires that individuals must apply for and be determined ADA eligible in order to use Paratransit Services.

SARTA's Proline (ADA Paratransit service) is a "Shared Ride" service. Passengers usually ride with others who are traveling in the same general direction therefore drivers may stop to pick up or drop off passengers during a person's trip. Drivers cannot go inside to get passengers or take them inside their destination. SARTA **only** provides transportation services.

SARTA's Paratransit Service is not:

1. A social service sponsored transportation program.
2. For special event group trips.
3. Designed to meet the needs of every disabled person, some people may require more service or assistance than SARTA's Paratransit service can provide.
4. For individuals who can use the regular SARTA fixed route buses but do not want to.
5. A door to door service. Drivers may **only** escort passengers to and from outer doors of a building, upon request.
6. Responsible for the custodial care of passengers.
7. Capable of being a mobility aid for a passenger.

To apply for Proline, complete the following application which includes having the medical verification form completed by a physician licensed to diagnose your disability/condition.

SARTA notifies applicants of their eligibility determination no later than 21 days after SARTA has received the completed application, **including** the medical verification form.

Every question must be answered completely for SARTA to review your application. If all questions are not answered your application will be returned.

(More)

Eligibility

Eligibility is based on whether a disability/condition prevents one from performing the tasks required to ride the fixed route service some or all of the time. Age, income, access to, and distances to the nearest stop are not determining factors for ADA Eligibility. Factors that are evaluated are:

1. A person's ability to navigate the fixed route system independently.
2. How a person's functional disability/condition affects their ability to travel, all or some of the time to get to SARTA's fixed route services.

If you have any questions or need assistance completing this form, please call:
Proline: 330-455-2292 (Option #1, Priority Care Line)
Toll Free: 1-800-379-3661
TTY Ohio Relay Service: 1-800-750-0750

Submit original applications **ONLY** by mail or in person to:

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

SARTA'S ADA PARATRANSIT APPLICATION

Personal Information			
First Name:	**MI:**	**Last Name:**	**D.O.B.** ___/___/_____
Home Phone:	**Cell Phone:**		**Notification Calls: Home☐ Cell ☐**
Email address:	**U.S. Armed Forces Veteran** ☐ Yes ☐ No		**Existing Proline Client ID Number:**

Home Address		
Street Address (include Apt Name & Number/Lot Number) :	**City:**	**ZIP Code:**

Mailing Address (if different from above)		
Street Address:	**City:**	**ZIP Code:**

Emergency Contact		
First Name	**Last Name:**	**Phone:**

Applicant's Release

I understand the purpose of this evaluation form is to determine my eligibility for ADA Paratransit Service and will be kept confidential and shared only with professionals involved in evaluating my eligibility. I understand that providing false or misleading information could result in my eligibility status being revoked.

Signature:_____
Date:_____/_____/_____

If applicant is unable to sign this form, he/she may have someone sign on his/her behalf.

Signature:_____Relationship:_____
Date:_____/_____/_____

General

1. Have you ever used SARTA's fixed route service? □ Yes □ No

   If yes, which routes?

   _____

   If no, why not?

   _____

2. List the 3 most frequent destinations you travel to and how you get there?

   Destination Name_____

   - Address_____
   - How frequently do you travel to this location in a month? _____
   - Method of transportation_____

   Destination Name_____

   - Address_____
   - How frequently do you travel to this location in a month? _____
   - Method of transportation_____

   Destination Name_____

   - Address_____
   - How frequently do you travel to this location in a month? _____
   - Method of transportation_____

Disability/Condition

3. What disability/condition have you been diagnosed with?

   _____

4. Does your disability/condition prevent you from using SARTA's fixed route service? □ Yes □ No

   If answer is yes please explain.

   _____
   _____
   _____
   _____
   _____

5. Is your disability/condition considered permanent? □ Yes □ No
   a. If no, when will you be able to resume normal travel patterns? Date: _____

6. Does your disability/condition make it difficult for you to understand or remember how to find your way to and from bus stop? □ Yes □ No
   a. If yes, please explain.

   _____
   _____
   _____
   _____
   _____

7. Does your disability/condition change day to day or seasonally ☐ Yes ☐ No
   If yes, explain. _____

8. Please explain in detail how your disability/condition prevents you from using SARTA's Fixed Route services? _____

9. Are you able to do the following functions independently?

	Yes	Sometimes	No
Find your way between familiar locations			
Grasp coins, passes and handles			
Communicate address, destinations and telephone numbers on request			
Ask for, understand and follow directions			
Deal with unexpected situations or unexpected changes in routine			
Go up and down steps			
Recognize a destination or landmark?			
Walk or use a wheelchair/scooter 200 feet (*A city block)*			
Walk or use a wheelchair/scooter and travel ¼ mile (1,300 feet/just under 4 ½ football fields)			
Balance while seated			
Follow written and oral instructions to pay bus fare			

Explain sometimes and no responses:

Mobility

10. Can you get to a bus stop nearest to your home by yourself? □ Yes □ No

    If no, explain._____

11. Does weather affect your ability to use SARTA's Fixed Route services? □ Yes □ No

    If yes, explain._____

Mobility Device

12. Please indicate any mobility aid devices you use when traveling. Please check all that apply.
    - Support Cane □
    - Long White Cane □
    - Crutches □
    - Service Animal □
    - Walker □
    - Oversized Walker □
    - Powered Wheelchair □
    - Manual Wheelchair □
    - Oxygen Tank □
    - Hearing Device □
    - Other:_____(Please specify)
13. If you use a wheelchair or scooter, is the combined weight of you and the device over 800 pounds?

    □ Yes, What is the total weigh? _____

    □ No

14. If you use a wheelchair or scooter, does your residence have a ramp for the device?

    □ Yes

    □ No, How many steps? _____

    How do you transport your device to street level?

    _____

15. Are you able to maneuver your device on and off ramp?

    □ Yes □ No

16. A Personal Care Attendant (PCA) is a person who will assist you to and from the bus. Do you require a (PCA)? □ Yes □ No

    If yes, please explain. *Note Driver is not PCA

    _____

    _____

    _____

Medical Verification Form

This form shall be completed by a **physician** licensed to diagnose your condition or disability and is able to provide the needed information that would help determine eligibility for ADA paratransit service. Incomplete forms will be returned.

Patient Information			
Patient First Name:	**MI:**	**Patient Last Name:**	**D.O.B.____/___/____**

Physician Information		
Physician First Name:	**Physician Last Name:**	**Title (DO, MD, etc.):**
Name of Practice:		**Medical License No.:**
Street Address:	**City:**	**ZIP Code:**

Date of applicant's last visit: _____

Medical diagnosis of disability/condition:

_____

_____

_____

_____

Please describe in detail the impact this disability/condition has on the applicant's ability to use SARTA's Fixed Route services:

_____

_____

_____

_____

_____

_____

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

Physician's Signature_____ **Date**: _____

The **original** Medical Verification Form must be received within 30 days of the ADA Paratransit Application. Applications will only be considered completed if both the ADA Paratransit Application and Medical Verification Form are received. Copied, faxed, or scanned forms will not be accepted. Incomplete forms will be returned