APPLICATION FOR GPTC's ACCESS219 PARATRANSIT SERVICES

Both this form AND your Professional Verification form MUST be COMPLETELY filled out in order to be processed. Please note: This is a two (2) sided document.

Please check one of the following:

_____ New application (you are NOT a current paratransit rider)

_____ Request for re-certification (you have been asked to update your current application)

PART ONE (Applicant Information)

1. Name _____
FIRST MIDDLE INITIAL LAST

2. _____Male _____Female **3.** Date of Birth _____/_____/_____
MONTH DAY YEAR

4. Street Address _____Apt/Ste # _____

5. City, State_____ Zip Code _____

6. Contact Number/s (please include area code) _____

7. If you use a different mailing address, please provide it here: _____

_____

8. If you prefer communication via e-mail, please provide your e-mail address:

_____

9. Please provide a description of your residence (color, brick/siding, number of stories, etc.). Please include landmarks or cross streets if necessary:

_____ House _____ Apartment Bldg _____ Nursing/Group Home

_____
_____
_____
_____
_____

10. Emergency Contact Person: _____
FIRST LAST

_____
PHONE NUMBER(S)

11. Please check which of the following best describes your living situation:

_____ I live independently _____ I live with family/friends who assist me

_____ I receive Home Health Services _____ I live in a Twenty-Four (24) Hour Care or Skilled Nursing facility

_____ I live in an Assisted Living Facility

12. Do you have a current Indiana Driver's License or Picture ID? _____Yes _____No

ID# _____Expiration Year_____

PART TWO (Disability Information)

1. Please tell us what type of disability or health issue prevents you from using GPTC (Gary Public Transportation) fixed route (regular) bus services? Check all that apply:

_____ Physical _____Mental _____ Blindness/Visual Impairment

_____ Deaf/Hearing Impairment _____ Cognitive/Developmental _____Health Issues

2. Please provide more specific information about your disability and/or health issue: _____
_____
_____
_____
_____
_____

3. Please explain **HOW** your disability and/or health issue prevents you from using fixed route bus services: _____
_____
_____
_____
_____

4. Are the conditions you described: _____Permanent _____Temporary _____I don't know

5. Do these conditions change day to day in a way that affects your ability to use fixed route services? _____Yes _____No

6. If you use a wheelchair or electric scooter, are you able to transfer to a regular chair in the vehicle?

_____Yes _____Yes. But, I prefer not to. _____No

7. Is your wheelchair or scooter:

_____ More than 30 inches wide? _____ More than 48 inches long?

8. Is the combined weight of the device and occupant more than 600 pounds? ___Yes ___No

9. If you are blind/visually impaired, have you received training to help you get around the community?

_____ Yes _____ Yes. But, I am not confident in my skills. _____No _____I would like to

10. If you have a cognitive, developmental or mental disability, how does it impact you?

_____ difficulty with communication _____ difficulty in remembering
_____ other (please explain):_____
_____

11. Please check any and all of the mobility aids and/or equipment you use:

_____ Regular Cane _____ White Cane _____Walker _____Crutches
_____ Braces/Prosthetics _____ Manual Wheelchair _____Power Wheelchair
_____ Power Scooter _____Portable Oxygen _____ Service Animal (describe below):
_____

12. Do you usually travel with someone who assists you? ___Always ___Sometimes ___Never
If "always" or "sometimes", what kind of help do they provide? _____
_____

13. Do you require a Personal Care Attendant (PCA)? _____ Yes _____ No

14. How far can you walk or roll without assistance? _____ Not at all _____ To the front curb
____ A city block (200 ft) _____ 3 blocks _____ 6 blocks _____ 9 blocks _____Not sure

15. Are you able to wait by yourself for a bus? ___ Yes ___ If the stop has a shelter & bench
____ No (Please Explain): _____
_____

16. Do any of the following situations apply to you?

___ Inability to climb three 10-inch steps ___ Inability to cross busy intersection
___ Problems with physical barriers (snow-covered or inaccessible sidewalks, curb cuts).
___ Extreme sensitivity to cold weather ___ Extreme allergy/environmental sensitivities
___ Extreme sensitivity to hot weather ___ Hyper-fatigue/frailty ___ Night blindness
___ Balance problems ___Communication difficulties ___ other (please describe):_____
_____

PART THREE (Travel Information)

Our goal is to provide safe, reliable economical and superior service to our ridership. There are some real advantages to using fixed route services whenever possible. It is much less expensive and instead of making your plans ahead of time, you can decide to ride the same day that you want to travel. We also know that some people have expressed concern about their ability to use fixed route services. This information will help us to ensure that you have access to the kind of information and support that may give you more options.

1. Have you ridden GPTC fixed route buses in the past? ___Yes ___No

2. If yes, what difficulties did you encounter? If no, what keeps you from trying? _____
_____
_____
_____

3. Do you think you might benefit from travel training? ___ Yes ___ No ___ I don't know.

4. What other means of transportation have you used? Please check all that apply:

_____ Drove my own vehicle _____ Rode with family/friends _____ Taxi/Cab Service
_____ Demand-response (LCEOC, NWICA, Trade Winds, Dial-A-Ride, etc.)
_____ Medical Transport Companies (please name):_____
_____ Other modes of transportation (please describe):_____
_____

5. Where are would you usually be traveling to? Please check all that apply:

___ Employment/Job ___ Shopping ___ Recreation/Visiting ___ School ___ Dialysis Treatment
___ Other Medical Facility or destination (please describe):_____
_____
_____

6. Why is it **IMPOSSIBLE** and not just difficult/inconvenient for you to now travel on a regular/fixed route bus? ***This question MUST be completed***
_____
_____
_____
_____
_____
_____
_____
_____
_____

PART FOUR (Signatures and Verification)

I understand that the purpose of this application is to determine if I am eligible to use Paratransit services. I understand that it must be **FULLY** completed in order for GPTC to process, including Section Five (to be completed by a verifying professional). By signing this document, I certify that the information provided in this application is true and correct to the best of my knowledge. I understand that falsification of information could result in a loss of potential eligibility as well as a penalty under the law. I agree to notify GPTC if any of the conditions I have described change in a way that may affect my eligibility.

_____

SIGNATURE OF APPLICANT

Date Signed:_____/_____/_____

MONTH DAY YEAR

_____

SIGNATURE OF PARENT/LEGAL GUARDIAN OF APPLICANT UNDER 18 YRS OF AGE

If this application has been completed by someone other than the person requesting certification as an eligible Paratransit rider, that person **MUST** complete the following:

IMPORTANT NOTE:
IMPLEMENTATION OF BEST PRACTICES BY PROJECT ACTION DICTATES, THAT A PARTY OTHER THAN SOMEONE REPRESENTING THE DESTINATION TO WHICH A RIDER IS TRAVELING MUST COMPLETE THE APPLICATION. PARTICULARLY, THE PORTION WHICH IDENTIFIES SPECIFIC INFORMATION REGARDING THE MANNER IN WHICH THE RIDER'S DISABILITY IMPACTS HIS/HER ABILITY TO USED FIXED ROUTE.

Name _____

FIRST MIDDLE INITIAL LAST

Address _____

City/Town _____ State _____ Zip Code _____

Phone Number _____

DAYTIME EVENING MOBILE

Reason for your assistance? _____

_____

Signature _____ Date _____

REMINDER! YOU MUST SIGN AND FORWARD THE "PROFESSIONAL VERIFICATION FORM" TO THE PERSON YOU DESIGNATE, THEN INCLUDE A COMPLETED FORM WITH YOUR APPLICATION YOU SUBMIT TO GARY PUBLIC TRANSPORTATION CORPORATION

PLEASE SEE OTHER SIDE FOR "RIDERSHIP SURVEY"

RIDERSHIP SURVEY

If you currently use or have used Access219 Paratransit services, please take a few minutes to complete this survey. We appreciate your help and welcome your feedback, comments and suggestions.

1. How would you rate our scheduling process? _____ Excellent, never have any problems _____Good, usually works fine. _____ Unsatisfactory (please explain): _____
_____
_____

2. Is your ride: ___ Always on time ___ Usually on time ___Sometimes ___ Often Late

3. Are there any problems with knowing when your ride has arrived? _____
_____
_____

4. How would you rate our drivers? _____ Excellent, never have any problems _____Good, usually do a good job. _____ Unsatisfactory (please explain): _____
_____
_____

5. Do the drivers have any difficulty using the lift, tie downs, etc.? ___ Never ___ Not that I'm aware of. ___ Sometimes ___ Yes, very often. (Please explain): _____
_____
_____

6. Are our driver/staff courteous? ___ All of the time ___ Most of the time ___ Some of the time ___ None of the time (please explain): _____
_____
_____

7. How would you describe the condition of our vehicles? ___ Excellent, always clean ___Good ___ Usually good ___ Not good ___ Very poor (please explain): _____
_____
_____

8. Any comments or suggestions? _____
_____

Professional Verification Form

(To be submitted with the application for GPTC's ACCESS219 Paratransit Services)

PLEASE NOTE: THIS IS A TWO (2) SIDED DOCUMENT

SECTION I: AUTHORIZATION TO RELEASE INFORMATION

(Applicant must complete this page before giving the entire form to the professional you name below.)

Applicant's Name _____
FIRST MIDDLE INITIAL LAST

Date of Birth _____/_____/_____ Current Age _____

Applicant's Street Address _____

City/Town _____ Zip Code _____

Applicant's Phone Number(s) _____
HOME MOBILE WORK

I hereby authorize the following certifying professional(s) to release to the Gary Public Transportation Corporation (GPTC) specific information as requested. It is my understanding that this information will be used solely to determine my ADA Paratransit eligibility. I understand that I may revoke this authorization at any time. Unless revoked, this form will allow the professional named below to release information described for three (3) months after the date which appears below.

Printed name of professional _____
FIRST MIDDLE INITIAL LAST

___ General/Family physician ___ Physician Specialist ___ Psychiatrist/Psychologist
___ Licensed Optometrist ___ Certified Audiologist ___ Certified Rehabilitation Specialist
___ Other (please describe): _____

Applicant's Signature _____

Today's Date _____

Guardian's Signature (if applicable) _____

Today's Date _____

SECTION II: LETTER TO CERTIFYING PROFESSIONAL

Dear Certifying Professional:

The person whose signature appears on the attached release form has applied for certification as an eligible Paratransit Services rider. That application must include a completed "Professional Verification Form". The applicant is asking you to provide information related to how his/her disability or health issue impacts their functional capacity.

*Please note: **Federal Law** is very specific about **ADA** Paratransit eligibility. Which can be awarded to individuals who:*

1. *As a result of their disability cannot board, ride or disembark from a regular (fixed) bus route or light rail car.*

2. *Have a specific impairment-related condition which prevents them from getting to or from a bus stop.*

These definitions do NOT include persons who find it difficult or uncomfortable to get to and from bus stops. Diagnosis of a specific disability or medical condition does NOT necessarily mean that the applicant is qualified. Your assessment should be based solely upon functional capacity, not the applicant's age or economic status.

Gary Public Transportation Corporation (GPTC) does take into consideration those difficulties brought about by physical barriers on the path of travel. In some cases, individuals may be given "Conditional" certification based upon those factors, as well as, temporary disability, impact of excessively cold or hot weather.

If you have any questions, please feel free to call our ADA Coordinator at (219) 884-6100 Extension 106.

Thank you,

GARY PUBLIC TRANSPORTATION CORPORATION
2101 W 35TH AVE
GARY IN 46408

SECTION III: DISABILITY INFORMATION

A. GENERAL: ***This section must be filled out for all applicants.***

1. When is the last date you provided services to this individual? _____/_____/_____
MONTH DAY YEAR

2. How long have you provided services to this individual? _____/_____/_____
MONTH DAY YEAR

3. Please describe this individual's diagnosed disability or health issue: _____
_____
_____

4. Is this disability: ___ Permanent ___ Temporary (Est. recovery ___ Yrs ___ Mos ___Days)

5. Does the way that it manifests vary from day to day to the extent that it would affect the individual's ability to use fixed route services? ___ Yes ___ No ___ Possibly
Please explain: _____
_____

6. Is the individual impacted by extreme temperatures? ___ Somewhat ___ No ___ Unknown
___ Yes, cold or wind chill less than ___ degrees ___Yes, heat index of more than ___ degrees

7. Does the individual use any of the following? Check all that apply: ___ Support Cane
___ Walker ___ Braces/Prosthetics ___ Manual Wheelchair ___ Power Wheelchair
___ Scooter ___ Service Animal (please describe): _____
___ Other (please describe):_____
_____

8. In your opinion, how far would this individual be able to walk or roll without assistance?
___ not at all ___ to the front curb ___ a city block (200 feet) ___ 3 blocks ___ 6 blocks
___ 9 blocks ___ not certain ___ additional comment if any: _____
_____

9. In your opinion, would the individual be able to wait alone for a bus?
___ Yes ___ Yes, with shelter & bench ___No ___ Unknown

10. If the individual has a wheelchair or scooter, can he/she transfer to a regular chair on a bus?
___ Yes ___ Yes. But, not advisable. ___No ___Unknown ___ N/A

11. Do either of the following situations apply to the individual? Please check all that apply:
___ Inability to climb three 10-inch steps ___ Difficulty with crossing busy intersections
___ Difficulty with balance ___ Inability to walk or stand for extended periods of time
___ Problems with physical barriers (snow-covered or inaccessible sidewalks, curb cuts, etc.)

12. Is there any other relative information you would like to add? ___ No ___ Yes:
_____
_____

13. Does the individual have any of the following? Please check all that apply:

___ Cognitive Disability ___ Emotional Disability
___ Mental Illness ___ Neurological/Head Injury

14. Please describe the functional limitations the individual experiences:
_____
_____
_____

15. Does the individual have problems with reading, remembering or communication? ___Yes ___ No ___ Somewhat ___ Uncertain If "yes" or "somewhat", please explain: _____
_____
_____

16. Is the individual's judgment or inhabitation impaired? ___ Yes ___ No ___ Somewhat
If "yes" or "somewhat", please describe to what extent or give an example: _____
_____
_____
_____

17. Does the individual experience seizures? ___ Yes ___ No ___ Unknown
What type: _____ Date of last known seizure: ___/___/___

18. Does this individual experience any of the following: ___ Auditory/Visual Hallucinations ___ Delusions ___ Disassociation ___Anxiety or Panic Attacks ___ Other (please describe): __
_____
_____

19. Travel independently, would the individual have the ability to _____. Please check all that apply:
___ Get help if lost ___ Recognize & avoid danger ___ Cross streets safely
___ Follow written directions ___Communicate needs ___Process Information
___ Other (please describe):_____
_____
_____

20. Is there any other relative information you would like to add? ___ Yes ___ No
_____
_____

B. SPECIFIC: *Please check & complete only those sections that apply to the applicant.*

Blind/Visually Impaired

1. Is the individual? ___ Totally blind ___ Legally blind
___ Visually impaired (Please provide visual acuity measurements):_____
_____
_____

2. Does the individual experience: ___ Sensitivity to light ___ Night blindness

3. Does the individual use: ___ Long White Cane ___ Service Animal (what kind): _____

4. To your knowledge, has the individual had orientation and mobility instruction to enable him/her to get around the community independently? ___ Yes ___ No ___ Unknown

5. In your opinion, would the individual benefit from such training? ___ Yes ___ No
___ Unknown

6. Is there any other relative information you would like to add? ___ No ___ Yes: _____
_____
_____
_____

Deaf/Hearing Impaired

1. Is the individual? ___ Totally Deaf ___ Hearing Impaired

2. When communicating with hearing people, does he/she use: ___ American Sign Language
___ Lip Reading ___ Note Writing ___ Unknown

3. Is there any other relative information you would like to add? ___ No ___ Yes: _____
_____
_____
_____
_____

MEDICAL/HEALTH RELATED

1. Please describe the individual's medical condition: _____
_____
_____

2. Does the individual use portable oxygen? ___ Yes ___ No ___ Unknown

3. Does the individual have extreme allergy/environmental sensitivities? ___ Yes ___ No ___ Unknown

4. How does the individual's medical condition impact his/her functionality? _____
_____
_____
_____
_____
_____
_____

5. Is there any other related information you would like to add? _____
_____
_____
_____

C: CERTIFYING PROFESSIONAL SIGNATURE/ CONTACT INFORMATION

Signature _____

Printed Name _____

Street Address _____

City/Town_____ State _____ Zip Code _____

Contact Phone Number _____ Fax Number _____

I am a/an:
___ General/Family Physician ___ Physician Specialist ___ Psychiatrist/Psychologist
___ Licensed Optometrist __ Certified Audiologist __ Special Education Admin/Teacher
___ Certified Rehabilitation Specialist ___ Certified Independent Living Specialist
___ Other (please describe): _____
_____