



Brazos Transit District

ADA Paratransit Transportation Application

PART A and PART B must be completed and submitted together in order to process the application.

Office Use ONLY: Approved Denied
Date: _____ Client: _____

PART A: To be completed by applicant or on behalf of the applicant.

PLEASE PRINT

Date: _____ Gender: Male Female
Name: Last: _____ First: _____ MI: _____
Residence Street Address: _____
Apt No: _____ Is the apartment complex gated: Yes _____ No _____
City: _____ State: _____ Zip: _____
Mailing Address (if different): _____

Date of Birth: _____ Home Phone: _____
Cell Phone: _____ Work Phone: _____

APPLICANT EMERGENCY CONTACTS:

Primary Contact:

Name: _____
Relationship: _____
Address: _____
Home Phone: _____ Cell Phone: _____

Secondary Contact:

Name: _____
Relationship: _____
Address: _____
Home Phone: _____ Cell Phone: _____

APPLICANT INFORMATION:

1. Are you a: Current ADA Paratransit Rider New Applicant
2. Which of the following condition(s), if any, prevent you from using the Fixed Route system (city buses) in Bryan/College Station, Lufkin, Nacogdoches, Diboll or Liberty/Dayton/Ames?

- | | | |
|-----------------------------------|---|---------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Intellectual |
| <input type="checkbox"/> Physical | <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Disability |
| <input type="checkbox"/> Visual | <input type="checkbox"/> Deaf | <input type="checkbox"/> Other _____ |

3. Briefly explain how your disability prevents you from using the fixed route buses (city buses).

4. Is your disability or health condition: Permanent Temporary?

If temporary; expected to last until: _____

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

- | | |
|--|---|
| <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Service Animal |
| <input type="checkbox"/> Wheeled Walker | <input type="checkbox"/> Hearing Device |
| <input type="checkbox"/> Cane | <input type="checkbox"/> Leg Braces |
| <input type="checkbox"/> Foldable Wheelchair | <input type="checkbox"/> Scooter |
| <input type="checkbox"/> Foldable Walker | <input type="checkbox"/> Oxygen Tank |
| <input type="checkbox"/> Segway | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Power Wheelchair | |

Note: The ADA (Americans with Disabilities Act) states that a transportation provider may decline to carry a mobility device/occupant if the combined weight exceeds that of the lift specifications set by the manufacturer, or if the carriage of the mobility device is demonstrated to be inconsistent with legitimate safety requirements. BTD will transport all mobility devices that meet the vehicle manufacturer limits, which states that BTD may not be able to accommodate mobility devices longer than 48" or wider than 30" or weigh more than 600 pounds.



6. Can you climb ten steps with a handrail, without assistance from another person?

YES

NO

If no, why not? _____

7. If applicant has a disability affecting mobility, please indicate what distance you are able to travel without the assistance of another person.

less than 200 ft.

5 to 6 blocks

1 to 2 blocks

7 to 8 blocks

3 to 4 blocks

9 or more blocks

8. Do you travel with a Personal Care Attendant (PCA)?

YES

NO

Sometimes

9. Have you ever used the fixed route service (city buses)?

YES

NO

10. If YES, why are you no longer able to use the fixed route city buses?

11. If you have a cognitive disability, are you able to: (check all that apply)

Give name, address and telephone numbers upon request?

Recognize a destination or landmark?

Deal with unexpected situation or unexpected changes in routine?

Ask for, understand, and follow directions?

Safely and effectively travel through crowded and/or complex facilities?

Explain: _____

12. Describe your neighborhood: (check all that apply)

Sidewalks in front of your residence.

Wheelchair ramps at your residence.

Paved road in front of your residence.

Unpaved road in front of your residence.



ACKNOWLEDGEMENT

I agree to pay the exact fare for each trip. I agree to notify Brazos Transit District of any changes in my mobility status, which may affect my eligibility to use the service. I also understand that failure to adhere to the policies and procedures will be grounds for suspending or revoking my application and right to use the Brazos Transit District ADA Paratransit service. I understand and agree to hold Brazos Transit District harmless against all claims or liability for damages to any person, property, or personal injury occurring as a result of my failure to equip or maintain the safety measures of the adaptive equipment or service animal that I require for mobility. I understand that providing false and misleading information could result in my eligibility status being terminated. I have read and fully understand the conditions for service outlined above and agree to abide by them.

To the Applicant: I give permission for Brazos Transit District staff to contact the professional who has filled out this application or given supplemental verification of my condition. Sign below to allow the release of information from the professional who will be filling out this form. I hereby request that information pertaining to limitations that prevent me from using fixed route buses be released to Brazos Transit District for further determination of my ADA Paratransit eligibility.

Print Name: _____

Applicant's Signature: _____ Date: _____

If someone other than the person requesting certification has completed this application form, please complete the following:

Print Name: _____

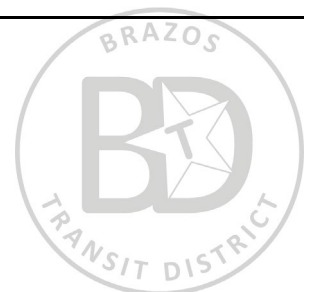
Relationship to Applicant: _____ Day Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Agency Name (If applicable): _____

Signature: _____ Date: _____



PART B: TO BE COMPLETED BY A MEDICAL PROFESSIONAL ONLY

PART A and PART B must be completed and submitted together in order to process the application.

Health Care Professional:

The applicant is asking you to review the information on this application and to complete and sign part B of this form certifying that they have a disability that prevents them from using fixed route buses (city buses) in Bryan/College Station, Nacogdoches, Liberty, Cleveland, Dayton, Ames, Diboll and Lufkin. This information will be used to help determine whether or not the applicant needs to use ADA Paratransit (origin to destination) service or is able to use fixed route service for their travel needs.

To be completed by a medical professional who is knowledgeable about the applicant's functional ability.

We need to know the limitation/s of their disability that limits their ability to ride the fixed route bus. The following is necessary for us to process this applicant's request:

- Thorough details of the applicant's functional limitations, and how they inhibit that person's ability to board and use a fixed route bus.
- Thorough details of the applicant's cognitive limitations, and how they inhibit that person's ability to navigate using a fixed route bus.
- Thorough details of the applicant's physical limitation, and how they inhibit that person's ability to reach a bus stop or the destination from a bus stop.

Under the Americans with Disability Act (ADA), if a person has the functional capability to use Brazos Transit District's fixed route buses, that person is not eligible for ADA Paratransit service (origin to destination). Disability alone and distance to and from a bus stop, by itself, does not qualify a person for Brazos Transit District's ADA Paratransit Service.

Thank you for your assistance. If you have any questions while completing this form, please feel free to contact Brazos Transit District at (979)778-4480 or (800)272-0039.



Name of Patient/Applicant: _____

Date of Birth: _____

TO BE COMPLETED BY A MEDICAL PROFESSIONAL ONLY

This form must be filled out by a professional who is knowledgeable about the applicants' disability and their limitations. Please check the appropriate box regarding the person completing this form:

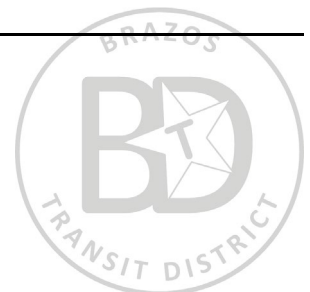
- | | |
|--|--|
| <input type="checkbox"/> Vocational Rehab. Counselor | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> O & M Instructor | <input type="checkbox"/> Mental Health Counselor |
| <input type="checkbox"/> Licensed Social Worker | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> Physician | <input type="checkbox"/> Podiatrist |
| <input type="checkbox"/> Respiratory Therapist | <input type="checkbox"/> Audiologist |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Optometrist |
| <input type="checkbox"/> Other _____ | |

1. Indicate nature of applicant's disability (check all that apply) *Medical Professional ONLY.*

- | | |
|---|---|
| <input type="checkbox"/> Impaired or assisted ambulation: Specify mobility aid: _____ | |
| <input type="checkbox"/> Cerebrovascular Accident | <input type="checkbox"/> Legally Blind |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Severely Visually Impaired |
| <input type="checkbox"/> Deaf/Hard of Hearing | <input type="checkbox"/> Alzheimer's |
| <input type="checkbox"/> Cardiac | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Dialysis | |

Pulmonary: Does applicant travel with Portable Oxygen Tank?
 Yes No

- Intellectual Disability (indicate one: Moderate Severe Profound)
- Mental Illness (Specify type) _____
- Seizures: Specify nature of: _____
- Arthritis: Specify extremity: _____
- Neurological Disability (Specify) _____
- Other _____



2. In your opinion can the applicant use the:

Fixed Route (city bus) OR ADA Paratransit (origin to destination)

If origin to destination service is needed, please describe the physical and/or cognitive condition and how it functionally prevents the applicant from using regular city buses:

3. What is the expected duration of the applicant disability?

Permanent

Temporary (Duration: from _____ to _____)

If the applicant has a cognitive disability, is the applicant able to:

• Give addresses and telephone numbers upon request? Yes No

• Recognize a destination or landmark? Yes No

• Deal with unexpected situations or unexpected change in routine?

Yes No

• Ask for directions and follow directions? Yes No

4. Does the applicant require a Personal Care Attendant?

No

Sometimes

Yes

Do not know

5. If vision impaired, what is the visual acuity:

Right eye _____ Left eye _____

Visual Field Restriction:

Right _____ Left _____

Visual impairment diagnosis: _____

6. Please indicate the primary mobility aid used when traveling in the community:

Cane

Crutches

Walker

Scooter

Segway

Prosthesis

Power Wheelchair

Service Animal

Hearing Device

Oxygen Tank

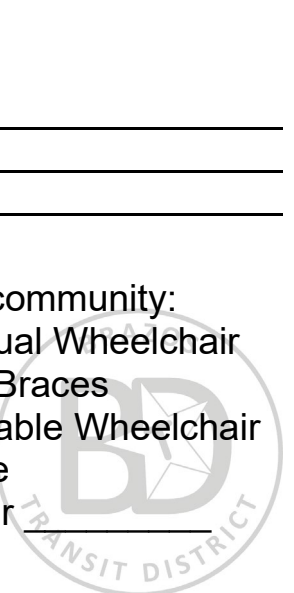
Manual Wheelchair

Leg Braces

Foldable Wheelchair

None

Other



7. How far can applicant walk or wheel themselves without assistance from another person? _____

8. Is the applicant able to wait outside in different weather conditions without support for 30 minutes?

Yes

No

Sometimes

If No or Sometimes: (Explain) _____

PROFESSIONAL CERTIFICATION *Medical Professional ONLY*

Qualified professional must complete this section. Please print or type.

Person Completing Form: _____

Professional Title: _____

Agency/Affiliation: _____

Business Address: _____

City: _____ State: _____ Phone: _____

Please return your completed application to:

By Mail:

Brazos Transit District
ADA Paratransit Applications
2117 Nuches Ln.
Bryan, TX 77803

By Fax:

Brazos Transit District
ADA Paratransit Applications
Fax (979)778-3606

If at any time you have any questions completing this application, please call Brazos Transit District at (979)778-4480 or (800)272-0039.



Brazos Transit District
OFFICE USE ONLY

Date Application Received: _____

Date Approved: _____ Date Denied: _____

Date Applicant Notified: _____

Staff Signature: _____

Eligibility Temporary Permanent

Eligibility Dates: _____ to _____

