Application for ADA Para-Transit Service

Para-Transit Service is specialized transportation service for persons with disabilities, seniors with disabilities, handicapped and who are unable to independently use PAT fixed routes.

Para-Transit is provided by public transportation systems as part of the requirements of the Americans with Disabilities Act (ADA).

In order to use ADA Para-Transit service, you must first be certified as eligible. Please read the following instructions before filling out the attached application form. All information that you supply will be kept strictly confidential.

1. Please answer FULLY all of the questions on the form, and return it to the transit system (Incomplete applications will not be processed, and will be returned to you for completion)

2. Your application will be reviewed, and an eligibility determination will be made within 21 days of receipt of a COMPLETE application. You will receive a letter as to whether or not you are eligible.

3. Eligible for all your travel needs on Para-Transit may be full eligibility or conditional eligibility depending on the nature of your disability or circumstances.

Thank You
PETERSBURG AREA TRANSIT
ADA PARA-TRANSIT ELIGIBILITY APPLICATION

If you have a disability that prohibits you from riding Petersburg Area Transit’s urban fixed route bus system, you may be eligible to receive Para-Transit Services thru Petersburg Area Transit in compliance with the Americans with Disabilities Act (ADA). This application will be used to determine the extent of your disability as it relates to using public transit services.

A few items to remember as you fill out the application...

- A friend or relative may fill out this application on your behalf. If someone fills out the form for you, Part D of the application must be completed.

- It is important that you answer every question on this application form. Please give as much detail as possible. We understand that some of your answers may be personal. Any information received will not be provided to any other person or agency not directly related to the certification process.

- Evaluation of your request cannot begin until we have received the completed form including the signed Part E, Authorization to Release Personal Information.

1. Upon approval you may go to the Petersburg Transit Station at 100 West Washington St. On the 2nd Tuesday of every month from 9am to 12pm to receive an ADA photo identification card.

Please remember:

- Reserve an advance reservation, door to door service.
- Drivers do assist passengers to and from the vehicle, in and out of seats.
- Please indicate on your ADA application if you require a Certified Aid to travel with you. A Certified Aid with their company I.D allows the Aid to ride for free.

Mail the completed application to: Petersburg Area Transit, 309 Fairgrounds Rd, Petersburg VA 23803. If you have any questions, please call the Petersburg Area Transit Administrative Office at (804) 733-2413.
ADA PARATRANSIT ELIGIBILITY APPLICATION

☐ New Application ☐ Recertification
Please print or type and all questions must be answered.

PART A: APPLICATION DATA

1. Name: ________________________________ Birth Date: _____________

2. Street Address: ________________________________
   City: ________________________________ Zip: ________________________________

3. Home telephone: ( ) __________ Work telephone: ( ) __________

4. Emergency Contact Person: ________________________________
   Day Telephone: ( ) __________ Evening telephone: ( ) __________

5. Race Status:
   _____ White or Caucasian Only _____ Black / African American Only _____ Hispanic/Spanish
   _____ American Indian or Alaskan Native Only _____ Asian Only
   _____ Native Hawaiian or Pacific Islander Only _____ Some Other Race Only
   _____ Two or More Races Combined _____ Race Unknown or Unreported

6. Do you normally use any of the following mobility aids? Yes_________ No _________
   _____ Manual Wheelchair _____ Electric Wheelchair _____ Powered Scooter (3 or 4 wheels)
   Do you have a handicap ramp that meets (Commonwealth of Virginia “Uniform State-Wide
   Building” code for (wheelchair ramps)? Yes_________ No _________

7. Do you need a personal care attendant (other than the operator of the passenger lift) to assist
   you to board, ride, or disembark from an accessible Para-Transit vehicle?
   _____ Yes _____ No _____ Sometimes
   Please explain when an attendant is needed:
   __________________________________________________________
   __________________________________________________________

Office Use Only:

Approval Date: ________________ Attendant: ___________________________
Denial Date: ________________ Photo I.D. Date: _______________________
By: __________________________ Expiration: __________________________
PART B: FUNCTIONAL INFORMATION

1. Describe your physical, sensory and/or mental limitation that prevents you from using the regular fixed-route bus.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

2. Are your disabilities: _____ Permanent _____ Temporary _____ Variable Until: _____________

3. What is the maximum time period you can wait without support? _____ Minutes.
   Is this time period affected by extremes of hot or cold weather? _____ Yes _____ No
   If yes, please describe your situation below:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

PART C: APPLICANT SIGNATURE

I hereby certify the information given in this application is correct.

Signature: ___________________________ Date: ______________________

PART D: PERSON OTHER THAN APPLICANT COMPLETING FORM

Print Name: __________________________________________________________

Address: ____________________________________________________________

Phone where you can be reached: (____) __________________________

Relationship to Applicant: _____________________________________________

_________________________ Signature of other person completing this form  __________ Date: ____________________
PART E: AUTHORIZATION OF PROFESSIONAL TO RELEASE PERSONAL INFORMATION

Incomplete forms will not be considered. A physician must verify your disability, prognosis and date of occurrence. Verification can be obtained directly from your physician or an agency that has record of the physician statement on file. This information must be submitted with the application and written on the physicians’ official letterhead or on the Physician Verification or Disability Form. The information you provide is confidential. It will not be shared with any other organization except as allowed by the Virginia Freedom of Information Act.

Verification of Information: I verify that all statements are true and correct to the best of my knowledge. I understand that supplying false information can disqualify my application and/or subsequent registration. I authorize Petersburg Area Transit to obtain verification of any information given in this application and to obtain essential medical information necessary for determination of Para-Transit eligibility. I also agree to submit myself an in-person evaluation by PAT and/or its acting agent for determination of Para-Transit eligibility.

I hereby authorize the limited release of information to the PAT about my functional travel abilities. The information released will be used solely to determine my eligibility for ADA Para-Transit Services.

Name of Professional: ____________________________
Agency/Organization: ____________________________
Phone Number: ____________________________
Authorized Signature ____________________________

I realize that I have the right to receive a copy of this authorization. I understand that I may revoke this authorization at any time.

Name of Applicant (Print Please) __________________ Date Signed __________

____________________________________
Signature of Applicant

*Verifying "Professional" may be a rehabilitation specialist, disability evaluator, mental health case worker, physician or other such individual knowledgeable of your disability or disabilities and functional travel abilities.
Petersburg Area Transit  
Para-Transit Services  
Under the Americans with Disabilities Act of 1990 (ADA)  
Physician Verification of Disability Form  
(Deliver or mail to your doctor)

Doctor: Please complete, sign and mail this Verification of Disability form as soon as possible. Your patient is being considered for enrollment in Petersburg Area Transit Para-Transit service. The information provided in this form is intended to verify any conditions/diseases that prevent your patient from using PAT fixed-route services.

Mail to: Petersburg Area Transit 309 Fairgrounds Road, Petersburg, VA 23803, ATTN: Cynthia Banks, Para-Transit Coordinator OR 
Fax to: 804-733-6439

Patient Name __________________________________________

DOB ________________________________ Date ________________

The patient named above: _______is currently being treated _______ _______ was formerly treated by me.

Name of condition / disease: ________________________________ Date of onset: ________________

Prognosis: ________________________________________________

Please explain how this prevents your patient from using regular bus service on a fully accessible vehicle (i.e. wheelchair lift equipped):

________________________________________________________

________________________________________________________

Does this patient require a travel aide or attendant? _____ Yes _____ No

Disability Status (select one):

_ Patient will be temporarily disabled of _________ months.

_ Patient is considered permanently disabled.

FOR VISUAL IMPAIRMENT

Visual Fields or Visual Acuity with best correction (must complete for both eyes): Right eye: _______ Left eye: _______

My signature below certifies that the above information is accurate.

Signature of Physician and Credentials (M.D., O.D.) ____________________________

License Number: ________________________________

__________ Print Physician Name and Credentials (M.D., O.D.)

State: ________________________________

__________ Physician's Office Phone Number

** Must be signed by licensed physician.

*** IMPORTANT NOTICE***

THIS FORM WILL NOT BE ACCEPTED UNLESS COMPLETED IN ITS ENTIRETY BY THE SIGNING PHYSICIAN.

6 of 6