ADA TRANSPORTATION APPLICATION

This is a 2 Part Application: (ADA Information # 1-800-514-0301)

Thank you for your interest in Star Transit transportation services.

Fixed Route buses provide service at designated bus stops along specific routes on set schedules. All our fixed route buses include wheelchair lifts to make riding possible for people with disabilities.

If your disability / medical condition or system accessibility/environmental barriers, prevents you from riding Fixed Route buses, you may be eligible for our deviated route service some or all of the time. Your ability to ride Fixed Route buses will be evaluated through use of this application, and in some circumstances an in-person interview.

What is the Americans with Disabilities Act (ADA)?

The Americans with Disabilities Act (ADA) is a civil rights law. The intent of the ADA' is to remove barriers that prevented people with disabilities from fully participating in life.

Under the ADA, Fixed Route buses are to be the primary means of public transportation for everyone, including people with disabilities.

Travel Training

Star Transit offers free one-on-one or group training to teach people with disabilities how to ride Fixed Route buses. Call our office for more information.

The Application Process

All information you supply is confidential and will only be used to help determine if you can ride Fixed Route buses or if you are eligible for a Deviated Fixed Route service.

INFORMATION:

To assist with proper evaluation of you ability to ride Fixed Route buses and/or need for Deviated Fixed Route service, you may be scheduled for an in-person interview. This interview will give applicants an opportunity to present issues in "their own words". It will also provide an opportunity to ask follow-up questions in order to have a clear understanding of the abilities and need of the applicant.

An in-person interview will be scheduled if it is determined that the Fixed Route may meet some or all of your needs. A thorough review of the routes needed to meet your needs will be conducted, including an analysis of the accessibility of the routes and stops, as well as the environmental barriers that may exist. An

in-person interview may also be conducted if a termination of eligibility cannot be made based on the application alone.

Applicants Name_____

All questions must be answered in order for your application to be considered complete.

You will be notified whether or not you are eligible for Deviated Fixed Route service within fifteen (15) days. If you are not eligible, information regarding how to appeal will be sent to you. In addition, a Star Transit staff member will contact you to assist you in understanding and / or utilizing the other transportation options that are available to you.

If you have any questions, need help filling out this application, or need an alternative format, please contact: STAR TRANSIT, 1-757-787-8322, or 1-757-787-8323. Ms. Terri Short

Please return your completed application to:

STAR TRANSIT Application Processing

P.O. Box 126

Tasley, Va. 23441

ADA Transportation Application

All Questions must be answered before application will be considered

PART A:

To be completed by applicant or on behalf of the applicant:

Applicant: ◯ **Male** ◯ **Female** **Date of Birth**_____

Last Name_____, **First**_____, **Middle**_____

Residence Address: Street_____, **Apt #**_____

Development_____

City_____,**State**_____,**Zip**_____

Mailing Address (if different)_____

Applicants Name _____

Please provide additional details regarding your address that will assist us in locating you.

(Road name and/ or directions, color of house, landmarks, name of nursing home, group home,etc)_____

_____

Home Phone ( )_____, Cell Phone ( )_____

Work Phone ( )_____Ext._____ TTY (__) E-Mail Address (Optional) _____

Emergency Contacts (Required)

Primary: Name:_____Relationship_____

Home Phone ( )_____Work Phone( )_____EXT.____

Cell Phone( )_____TTY( )_____E-mail (Optional)_____

Address_____

Secondary Contact: Name:_____Realationship_____

Home Phone ( )_____Work Phone( )_____EXT_____

Cell Phone( )_____TTY( )_____E-mail (Optional)_____

Address_____

APPLICANT INFORMATION:

1. **Are you a: ◯ Current Transit Rider ◯ New Applicant**
2. **Do you need information given to you in any of the following formats?**
   ◯ Yes ◯ No
   Large Print_____ Audio Tape_____ Braille
   Another Language_____ Other_____
3. **Which of the following condition (s), if any, prevent you from using the Fixed Route system?**
   Check all that apply: None_____, Physical _____, Visual _____
   Mental Illness _____, Brain Injury _____, Mental Retardation_____
   Deaf/Hard of Hearing_____, Other _____Briefly explain why this prevents you from using Fixed Route _____
4. **Is your disability or health condition**
   ◯ Permanent
   ◯ Varies Daily
   ◯ Temporary; expected to last until_____

5. **Please indicate the primary mobility aids you use when traveling in the community:**
   Support Cane___; Leg Braces____; Picture Board_____; Long White Cane____
   Crutches_____; Alphabet_____; Service Animal_____; Walker_____;
   Powered Wheelchair_____; Manual Wheelchair_____; Hearing Aid_____
   Prosthesis_____; Oxygen Tank_____; Scooter_____; Other_____

Note: Star Transit may not be able to accommodate you if your wheelchair or scooter is longer than 48" or wider than 30" or if you total weight with your wheelchair is more than 600 pounds. (ADA 37.165 Code)

6. **Can you climb three steps with a hand rail, without assistance?**
   - ◯ **Yes**
   - ◯ **No**
   - ◯ **Sometimes**
7. **Do you require a Personal Care Attendant (PCA) to help you travel? (A PCA is a person specifically employed or designated to help with your daily living needs.)**
   - ◯ **Yes**
   - ◯ **No**
   - ◯ **Sometimes**
8. **Have you applied and been denied the use of Deviated Route Service with STAR Transit before?**
   - ◯ **Yes**
   - ◯ **No**

If yes, how has your situation changed?_____

9. **Have you ever used or been trained to use STAR TRANSIT Fixed Route buses?**
   - ◯ **Yes**
   - ◯ **No**
10. **Check the items below that might help you ride STAR TRANSIT Fixed Route buses:**
    Help with trip planning_____, Wheelchair lift on the bus_____,
    Help Communicating_____, Bus stops closer to my home_____,
    Someone to teach me_____, Accessible route to my bus stop_____.
11. **What is the closest bus stop to your home?**
    Route #_____, I don't Know_____

APPICANT VERIFICATION

Application must be signed at the bottom to be considered complete.

Person completing this form if other than applicant (check one)

◯ **I certify that the information in this application is true and correct based upon the Information given to me by the applicant.**

◯ **I certify that the information provided in this application is true and correct based Upon my own knowledge of the applicant's health condition or disability or I have Legal authority to complete this application.**

Exceptions or additions:_____

Print Name_____, Day Phone ( )_____ Relationship _____

Address_____, City_____,State____, Zip_____

Signature:_____, Agency Name_____

Applicant Signature:

I understand that the purpose of this application form is to determine if there are times when I cannot use Star Transit Fixed Route buses and will require deviated route services. I understand that the information on this application will be kept confidential and shared only with the professionals involved in evaluating my eligibility. I certify that to the best of my knowledge, the information on this application is true and correct. I understand that providing false or misleading information could result in my eligibility status being terminated.

I give permission for STAR TRANSIT staff to contact the professional who filled out this application or given supplemental verification of my condition.

Applicant Signature_____, Date_____

Print Name_____

Part B

DOCTOR's / AGENCY's FORM

Applicant Name:_____

To be completed by a Professional who is knowledgeable about the applicant's disability.

Dear Professional:

Please assist us in our transportation eligibility determination process by providing additional information about the applicant stated on the Medical/ Professional Verification Form.

Please do not list diagnosis as reason for need of deviated route services. We need to know how the laminations that the applicant has will limit their ability to ride a Fixed Route bus. The following is necessary for us to proceed the applicant's request.

Thorough detail of the applicant's functional limitation(s), and how they inhibit that person's ability to board, use and disembark from a Fixed Route bus.

Thorough detail of the applicant's cognitive limitation(s), and how they inhibit that person's ability to navigate using a Fixed Route bus.

Through detail of the applicant's physical limitation(s), and how they inhibit that person's ability to reach a bus stop or destination from a bus stop.

Under the American's with Disabilities Act (ADA), if a person has the functional capability to use STAR Fixed Route buses, that person is not eligible for Deviated Fixed Route Services . Disability alone and distance to and from a bus stop, by itself, do not qualify a person for STAR Deviated Fixed Route Services.

All of STAR Fixed Route buses offer lift equipped buses that are available to person who have difficulty or who unable to use steps to board and disembark the bus. Also, STAR offers travel training for persons who need individualized training using the Fixed Route buses.

If you think that the applicant could benefit from the services stated in the paragraph above, please make a note on the verification form so that their eligibility can be better determined and proper services can be provided.

Thank you for your assistance. If you have any questions while completeing the verification form, please feel free to contact us at (757) 787-8322. STAR TRANSIT, P.O. Box 126, Tasley, Va. 23441

Applicants Name_____

ADA ELIGIBILITY INFORMATION
MEDICAL / PROFESSIONAL VERIFICATION FORM

To the Applicant:

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 my limitations that prevent me from using Fixed Route Buses be released to STAR Transit for further determination of my ADA Deviated Route Services eligibility.

Signature:_____ Date:_____

To the person completing this form: _____

1. **Indicate the nature of applicant's disability (check all that apply)**
   - ◯ **impaired or assisted ambulation: Specify mobility aid:_____**
   - ◯ **Arthritis: Specify extremity:_____**
   - ◯ **Cerebrovascular Accident**
   - ◯ **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) Moderate,_____ Severe,_____ Profound,____**
   - ◯ **Cerebral Palsy**
   - ◯ **Autism**
   - ◯ **Deaf / Hard of hearing**
   - ◯ **Seizures: Specify natures of: _____**
   - ◯ **Mental Illness**
   - ◯ **Other_____**

Applicants Name_____

2. How does the applicant's disability limit their ability to use a lift equipped Fixed Route bus?
   _____.

   _____.

   _____.
3. What is the expected duration of the applicant's disability?

◯ Permanent
◯ Temporary Expected duration:_____

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:_____

Clinic / Agency:_____

Address:_____

_____

Phone (_____)_____