

# Request for Certification of ADA Eligibility

Valley Transit provides specialized transportation for people with disabilities who are unable to use the fixed route bus system. This service, called Valley Transit II, is administered by Valley Transit and provided under contract by Running, Inc. under the requirements of the Americans with Disabilities Act (ADA). The paratransit eligibility process is also an ADA requirement.

The information obtained in this certification will be used only for the provision of Valley Transit and Valley Transit II transportation services. It may be shared with other transit providers to facilitate travel in their areas, but will not be provided to any other person or agency.

Please type or print.

Personal Information

1. Last name \_\_\_\_\_ First name \_\_\_\_\_ M.I. \_\_\_\_\_

2. Address \_\_\_\_\_ Gender \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

3. Telephone number(s) (home) \_\_\_\_\_ (work) \_\_\_\_\_

4. Date of birth \_\_\_\_\_ Insurance Provider \_\_\_\_\_

Insurance ID Number \_\_\_\_\_

Medical Condition

5. What is the disability that prevents you from using fixed route service?

\_\_\_\_\_  
\_\_\_\_\_

Is this condition temporary?  Yes  No If "Yes," the expected duration is until \_\_\_ / \_\_\_ / \_\_\_

Are you on S.S.I. and/or Medical Assistance?  Yes  No

If "Yes" for Medical Assistance, what is your M.A. number? \_\_\_\_\_

6. How does this disability prevent you from using fixed route services? Please explain completely. (If necessary, continue on the back of this sheet.)

\_\_\_\_\_  
\_\_\_\_\_

7. Are there any other effects of your disability or other medical conditions of which Valley Transit should be aware? (If necessary, continue on the back of this sheet.)

\_\_\_\_\_  
\_\_\_\_\_

**Last name:** \_\_\_\_\_

The following information will be used to insure that an appropriate vehicle is used to provide your transportation and that an accurate analysis of your trip requests can be made.

8. Which, if any, of the following aids to mobility do you use? (*Check all that apply.*)

- Manual wheelchair     Electric wheelchair     Powered scooter     Walker  
 Personal care attendant     Guide/attendant animal     Cane     Crutches

9. Do you require a personal care attendant when you use paratransit?

- Yes     No     Sometimes

10. Please answer all the following questions:

Can you travel a half block without the assistance of another person?

- Yes     No     Sometimes \_\_\_\_\_

Can you travel ¼ mile without the assistance of another person?

- Yes     No     Sometimes \_\_\_\_\_

Can you travel ¾ mile without the assistance of another person?

- Yes     No     Sometimes \_\_\_\_\_

Can you climb 12-inch steps without assistance?

- Yes     No     Sometimes \_\_\_\_\_

If "Yes," how many in succession? \_\_\_\_\_

Can you wait outside without support for ten minutes?

- Yes     No     Sometimes \_\_\_\_\_

11. List the names of two people and/or agencies (if appropriate) that may be contacted in case of an emergency.

Name \_\_\_\_\_ Telephone number(s) \_\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Telephone number(s) \_\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_

**Mobility Needs**

**Emergency Contacts**

Last name: \_\_\_\_\_

12. If this application has been completed by someone other than the person requesting certification, he/she must supply the following information about him/herself.

Name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Daytime telephone number \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

13. In order for your request to be evaluated, it may be necessary to contact a physician or other professional to confirm the information that you have provided. Please complete the following information and authorization form.

The following (check one) is familiar with my disability and is authorized to provide Valley Transit with the information required to complete this certification.

Physician       Health care professional       Rehabilitation professional

Professional's name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone number \_\_\_\_\_

I hereby authorize the above professional to provide the required information to Valley Transit. Further, I certify that the information here and on the preceding pages is correct.

Signed \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Additional Contacts & Authorization

**IMPORTANT! This form must be filled out completely. Please forward completed forms to Valley Transit, 801 S. Whitman Ave., Appleton, WI 54914 or fax to 920-830-7599.**

Valley Transit will be responsive to all Requests for ADA Certification. However, the certification process may take up to 21-days after Valley Transit receives all necessary information. A personal visit for assessment may be required by Valley Transit.

Effective: January 2017

Completed by Certifier

Certifier's signature \_\_\_\_\_

Certifier's name (typed or printed) \_\_\_\_\_

Date(s) of certifier's interview(s) \_\_\_\_\_

**Decision:**  I.D. Card # issued \_\_\_\_\_  Denied  
 Referred to review panel

**Card class:**  Conditional  Unconditional  
 Temporary

If the disability is temporary, the expected end date is \_\_\_\_/\_\_\_\_/\_\_\_\_