For office use only

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.

This information obtained in this certification will be used only for the provision of Valley Transit and Valley Transit II transportation services.

1. Last Name _____ First Name_____
2. Home Address _____ City _____
3. Address (if different) _____
4. Is this a Temporary Address Yes ☐ No ☐ Release Date ____/____/_____
5. City _____ County _____ State _____ Zip _____
6. Date of Birth ___/____/____ Phone _____ Cell _____ Work_____
7. Are you on Medical Assistance (optional)? Yes ☐ No ☐
8. Do you have a Managed Care Organization? If yes, select the organization below (optional):

   Community Care ☐ Iris ☐ Lakeland ☐Inclusa ☐ other ☐

   Explain other _____
9. Would you like to list the names of two people and / or agencies that may be contacted in case of an emergency (optional)?

   Name _____ Phone _____

   Address _____ Relationship _____

   Name _____ Phone _____

   Address _____ Relationship _____
10. What is the disability the prevents you from using fixed route service?

    _____

    _____
11. How does the disability prevent you from using the fixed route services? Please Explain Completely. (If necessary, continue the back of this sheet.)

    _____

    _____

Effective: May 2026

12. 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.)

_____

_____

_____

13. Is this condition temporary? Yes ☐ No ☐ If "yes" the expected duration is until _____/_____/_____

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

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

Manual Wheelchair ☐ Electric Wheelchair ☐ Power Scooter ☐Walker ☐

Personal Care Attendant ☐ Guide / Attendant animal ☐ Cane ☐ Crutches ☐

15. Will you be traveling with a personal care attendant?

☐Yes ☐ No ☐ Sometimes _____

16. Please answer 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 of a mile without the assistance of another person?

☐ Yes ☐ No ☐ Sometimes _____

Can you wait outside without support for ten minutes?

☐ Yes ☐ No ☐ Sometimes _____

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 _____ Phone _____/ _____ / _____ Date __/__/__

City _____ State _____ Zip _____

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 **AUTHORIZATION TO RELEASE MEDICAL INFORMATION** on the next page of this application.

Further, I certify that the information on all pages of this application are correct.

Signed _____ Date ____/____/_____

Important! This form must be filled out completely including the Authorization to Release Medical Information.
Please forward completed forms to
Valley Transit,
801 S Whitman Ave.,
Appleton, WI 54914

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.

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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 ___/___/___

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

As part of your paratransit eligibility determination, Valley Transit may contact your current doctor for information on your medical condition and your functional abilities.
Please list the doctor or licensed healthcare professional most familiar with your condition. All information received will be kept confidential and only utilized by Valley Transit staff to determine your eligibility for ADA Paratransit Services. Refusal to provide this release will prevent Valley Transit from completing your eligibility determination and will result in a denial of your application.

VALLEY TRANSIT DOES NOT PAY FOR MEDICAL INFORMATION OR FORM COMPLETION FEES

Please print and complete all blanks

Patient First & Last Name: _____

____Physician ____Ophthalmologist ____Other: _____

Physician Name: _____

Name of Office/Practice Group: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____Fax Number: _____

Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by the Privacy Regulation.

CERTIFICATION AND AUTHORIZATION

I understand that falsification of information may result in denial of Valley Transit paratransit service. I authorize the licensed health professional listed above to release to Valley Transit information about my disability and its effect on my functional ability to travel on the fixed route bus. Unless earlier revoked in writing, this form permits the professional listed to release information to Valley Transit up to one year from the date below.

Applicant Signature: _____ Date _____

Print Name: _____