Pulaski Area Transit
ADA Step #1
Request for Certification of Eligibility

Pulaski Area Transit (PAT) ADA Service provides persons who, due to a disability, are unable to use Pulaski Area Transit’s public fixed route transportation. Please complete this application as thoroughly as possible and to the best of your ability. If there are questions you cannot answer, or if you need assistance to complete this form please call Pulaski Area Transit (540-980-5040) for assistance. This is step 1 out of 2 steps that need to be completed in order for your eligibility to be determined. The purpose of this form is to provide an opportunity for you to describe barriers in the environment and how your disability prevents you from using Pulaski Area Transit’s fixed route bus service. The more information you provide, the better PAT will understand your ability and travel challenges.

The second step (step #2) will be sent to your physician, indicated on the last page of step #1 after our office receives it. Once both steps have been received, a determination of eligibility is made, and an information letter pertaining to this eligibility determination will be mailed.

Information contained in both steps will be kept confidential and shared only with physician involved in evaluating your eligibility.

I. GENERAL INFORMATION (PLEASE PRINT)

Name: ________________________________

Last First MI.

Street Address: ________________________________

(Bldg. Complex Apt/P.O.Box) ________________________________

City ________________________________ State _____ Zip ______

Do you live in Pulaski Town limits _____ Yes _____ No

***This does not determine your eligibility***

Day Phone ________________________________ Evening Phone ________________________________

Date of Birth _____/_____/____ _____ Male _____ Female
Person to be contacted in the event of an emergency. Please select someone who would not be riding in the vehicle with you:

Name ___________________________ Day phone ____________

Address __________________________________________________________

City ___________________________ State ________ Zip ________________

Relationship ___________________________ Date _____ / ____ / _____

To be completed if the applicant was helped by another person in the completion of this application.

Name ___________________________ Day phone ____________

Address __________________________________________________________

City ___________________________ State ________ Zip ________________

Relationship ___________________________ Date _____ / ____ / _____

I understand that the purpose of this form is to determine if I am eligible to ride PAT’s ADA Service, and that PAT staff may need to contact me for more information. I certify that I have been truthful in answering this form, and that the information I have provided is correct.

(Signature of Applicant or Responsible Party) ___________________________ Date _____ / ____ / _____

Will you need further materials in a different format? Please check one:

_____ Braille _____ Audio Cassette

_____ Large Print _____ Other _______________

Please read the following statements and check those that best describe the reason you are requesting PAT ADA eligibility.

_____ I can use PAT’s fixed route sometimes, if the conditions are right

_____ I believe I could learn to ride PAT’s fixed route, if someone taught me

_____ I have a visual disability that prevents me from ever getting to and from the bus, even with training

_____ The severity of my disability can change from day to day. I can ride the fixed route only when I am feeling well

_____ Because of my disability I can “never” use the bus by myself

_____ I can get to and from the bus stop if the distance is not too great and the route is Free from physical barrier

_____ There is no PAT fixed route bus service in my area
I am not really sure if I can use the bus
My disability makes it impossible to walk to and from the bus, even in good weather
I "do not" want to ride the fixed route bus
I am not able to use PAT’s fixed route for other reasons (please explain)

II. INFORMATION ABOUT YOUR DISABILITY AND MOBILITY EQUIPMENT

What disability(s) prevents you from safely using our accessible fixed route bus services? Please check all that apply:

_____ Physical
_____ Mental/Cognitive
_____ Other:
_____ Mental Illness
_____ Visual Impairment

Have you had a disability for more than one year? _____ Yes _____ No

Is your disability permanent? _____ Yes _____ No

If no; how long do you expect to have your disability _____ / _____ / _____

Does your disability change much from day to day? _____ Yes _____ No

Check any and every mobility aids you use (check all that apply):

_____ Manual Wheelchair
_____ Electric Wheelchair
_____ Large Electric Wheelchair
_____ Powered Scooter/Cart
_____ 3 Wheeled Scooter/Cart
_____ 4 Wheeled Scooter/Cart
_____ Prosthesis
_____ Other

_____ Service Animal
_____ White Cane
_____ Crutches
_____ Walker
_____ Leg Brace(s)/Cast
_____ Oxygen Tank
_____ Communication Device

Do you require a Personal Care Attendant (PCA) to accompany you when traveling? (If “Yes” that person is generally required for all trips.)

_____ Yes, I need assistance when I travel with:

_____ Mobility
_____ Transfers
_____ Other

_____ Reading
_____ Medication

_____ Eating

_____ All of the above

_____ No
Can you safely get to the ADA Service vehicle without the help of another person?
   ______ Yes       ______ No

III.  **USE OF FIXED ROUTE SERVICE**

- If you currently use PAT's fixed route bus service, do you need the assistance of another person? (check one) ______ Always _____ Sometimes _____ Never

- If you ever need another person's assistance, what does that person do for you?

- What is the closest bus stop to your home that meets your needs? Please give the location (ex: corner of Main)

- Can you safely get to this bus stop by yourself?
  (check one) ______ Always _____ Sometimes _____ Never
  If never or **sometimes**, please explain

- What is the most difficult part of riding PAT's fixed route bus service for you? (ex: bus moves before I am seated, etc.) Please list all:

- Can you ever safely cross the street by yourself?
  (check one) ______ Always _____ Sometimes _____ Never
  If **sometimes**, under what circumstances?

- Does your health condition or transportation disability change from day to day in a way that affects your ability to use accessible buses?
   ______ Yes, good on some days, bad on others
   ______ No, doesn't change
   ______ Don't know

- If **yes** or **don't know** was selected, explain why
IV. TRAVEL/MOBILITY TRAINING

- Have you ever received training to learn how to use the bus or travel around the community?
  (check one) _____ Yes _____ No

  If yes, which agency or person provided training? ____________________________

  When were you trained? ____________________________

  Did you successfully complete training? _____ Yes _____ No

  If no, why not? ____________________________

  Was your training route specific? _____ Yes _____ No

  Which route did you learn? ____________________________

  Would you like to participate in free training to learn to ride the bus?
  _____ Yes _____ No

V. WEATHER CONSIDERATIONS

- Does the weather affect your ability to use PAT’s fixed route bus service?
  _____ Yes _____ No

  If you answered yes, please explain how: ______________________________________

VI. YOUR FUNCTIONAL ABILITY

Your answers to the questions in this section will help us better understand your functional ability to specific areas. For each question, check one answer box. Your answers should be based on how you feel most of the time, under normal circumstances, using your mobility equipment, and whether you can perform this activity independently.

WITHOUT THE HELP OF SOMEONE ELSE CAN YOU:

1. Walk up and down three steps if there are handrails on both sides?
   _____ Always _____ Sometimes _____ Never _____ Not Sure

2. Use the telephone to get information?
   _____ Always _____ Sometimes _____ Never _____ Not Sure

3. Travel one block on the sidewalk when the weather is good?
   _____ Always _____ Sometimes _____ Never _____ Not Sure
4. If you are able to do this, how long does it take you?
   ____ Less than 5 minutes  ____ 5-10 minutes  ____ Not Sure

5. Cross the street, if there are curb cuts?
   ____ Always  ____ Sometimes  ____ Never  ____ Not Sure

6. Ride up and down wheelchair lift with handrails on both sides?
   ____ Always  ____ Sometimes  ____ Never  ____ Not Sure

7. Travel three level blocks on the sidewalk, when the weather is good?
   ____ Always  ____ Sometimes  ____ Never  ____ Not Sure

8. If you are able to do this, how long does it take you?
   ____ less than 10 minutes  ____ 10-15 minutes  ____ Not Sure

9. Wait 10 minutes in good weather outdoors without a place to sit?
   ____ Always  ____ Sometimes  ____ Never  ____ Not Sure

10. Step on and off the curb or sidewalk?
   ____ Always  ____ Sometimes  ____ Never  ____ Not Sure

11. Travel up or down a gradual hill on the sidewalk, if weather is good?
    ____ Always  ____ Sometimes  ____ Never  ____ Not Sure

12. Find your way to the bus stop, if someone shows you once?
    ____ Always  ____ Sometimes  ____ Never  ____ Not Sure

13. Currently travel by yourself?
    ____ Always  ____ Sometimes  ____ Never  ____ Not Sure

14. If you need the assistance of another person, what do they do for you?
    ____________________________________________________

15. Have you ever gotten lost when traveling alone?
    ____ Yes  ____ No, I never travel alone  ____ No, I’ve never gotten lost

16. If yes, were you able to find your way back?
    ____ Yes  ____ Yes, with help  ____ No

17. If you weren’t able to find your way back, what did you do?
    ____________________________________________________
18. The weather is good and there are no barriers in the way, what is the farthest you can walk or travel outdoors on a level sidewalk using your mobility aid?

____ I can’t travel outdoors alone   _______ Curb in front of my house
____ Less than 1 block                _______ 6 blocks
____ 3 blocks                          _______ More than 9 blocks
____ 9 blocks                          _______ Other (explain) __________
____ Not Sure

Visual Disability (Note: if you do not have a visual disability, please SKIP this section on move on to the next.)

- Name of eye disease/condition ___________________________

- My vision is worse during these conditions:
  _____ Bright Sunlight   _____ dimly lit or shaded places
  _____ Glare(from snow or vehicles) _____ I have no vision at all
  _____ See the same in different lighting conditions

- My eye condition is considered to be:
  _____ Stable _____ Degenerative _____ Other ____________________

- I have difficulty safely navigating through traffic conditions because of the following:
  _____ Insufficient peripheral vision
  _____ Inability to judge distances and speeds of oncoming vehicles
  _____ Difficulty seeing motorcycles and bicycles
  _____ Difficulty seeing traffic lights
  _____ Other ____________________

- I can easily see steps and curbs:
  _____ Yes _____ No

- I can safely find my destination without assistance:
  _____ Yes _____ No _____ Sometimes

VII. ENVIRONMENT AROUND YOUR HOME

- Do you have multiple steps at the entrance you use at your residence?
  _____ Yes _____ No

- How would you describe the terrain where you live/ (ex: steep hill, flat, long gradual hill, etc) __________________________
• Are there sidewalks in your neighborhood? _____ Yes _____ No

Please use this space to tell us anything else you would like us to know about your travel challenges and your ability to use PAT’s fixed route service:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Please list the trips you take most often, which you believe you would not be able to use PAT’s fixed route bus. Factors should include being able to get to the bus stop, wait, board and ride or disembark from the bus as well as get from the stop and your destination. This information will not be used to schedule any trips. You must call the office for all trip request.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

• Did you require any assistance to complete this form?

_____ Yes _____ No

If yes, how did that person assist you? _______________________________________

________________________________________________________________________

Please review the questionnaire to make sure you have answered all the questions to the best of your ability. Be sure you have completed every page and signed the form.
AUTHORIZATION FOR RELEASE OF DOCTOR’S INFORMATION

In order for Pulaski Area Transit to evaluate your request for eligibility, it is necessary for us to contact a physician who is familiar with your health condition or disability and your functional abilities and limitations. This information helps us to gain a better understanding of your disabilities and to find the eligibility type to suit your needs.

Please complete the following information request below and mail Step #1 to: Pulaski Area Transit, 141 E. Main Street, Suite 500, Pulaski, VA 24301. Pulaski Area Transit will then forward Step # 2 to the physician below.

___ Please check this box if you would like a copy of Step # 2 that will be mailed to your physician.

Name of physician

Type of Professional

Street Address

City, State, Zip

(_____) Phone number

I authorize the physician listed above to release to Pulaski Area Transit ADA Service information about my disability or health condition and its effect on my ability to travel on Pulaski Area Transit’s fixed route bus system. I understand that I may revoke the physician listed to release the information described up to 60 days from the date below.

________________________________________ Date: ____/____/____

(Signature of Applicant or Responsible Party)

All medical information, which you or a physician provided about your disability, will be kept strictly confidential.