RICHLAND COUNTY TRANSIT
RCT
232 North Main Street
Mansfield, Ohio 44902-7662
(419) 522-4504
Fax: (419) 522-3157

REQUEST FOR CERTIFICATION OF ELIGIBILITY FOR RCT DIAL-A-RIDE BUS
(ADA PARATRANSIT)

SECTION 1: To Be Completed by Applicant

The information provided on this form will be used ONLY to determine ADA paratransit eligibility by the RCT staff.

PLEASE TYPE OR PRINT CLEARLY

NAME_____

STREET ADDRESS_____

CITY_____ZIP CODE_____ BIRTH DATE_____

PHONE NUMBER (home)_____(work)_____

Describe the disability that prevents you from using fixed route service.

_____

_____

Is this condition temporary? _____yes _____no

If yes, list date you expect condition to no longer exist _____

IN CASE OF EMERGENCY: CONTACT PERSON:_____

CONTACT PERSON'S ADDRESS: _____

CONTACT PHONE NUMBERS:_____

PHYSICAL CONDITIONS THAT MIGHT CAUSE AN EMERGENCY: _____

_____

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2. Identify which of the following conditions prevent you from utilizing fixed route bus service.

(Please check all that apply to you)

Do you have difficulty:

_____ Traveling to the nearest bus stop It is _____ blocks from my home.

_____ Waiting at the bus stop for more than _____ minutes.

_____ Identifying the correct bus.

_____ Climbing steps to board the bus.

_____ Paying fare, completing transfers, communicating with the driver.

_____ Identifying the correct stop to signal the driver.

_____ Walking down bus steps.

_____ Other (describe)_____

3. Do you use any of the following mobility aids?

_____ Manual Wheelchair _____ Electric Wheelchair

_____ Three wheel Wheelchair _____ Walker _____ Tripod

_____ Crutches _____ Cane _____ Oxygen

_____ Guide Dog

_____ Aide/Helper NAME _____

4. Describe anything else about your disability that would prevent you from using fixed route bus service. _____

CERTIFICATION OF INFORMATION AND AUTHORIZATION TO PROVIDE INFORMATION

I Thereby certify that the above information is correct and I authorize the completion of the remainder of this form by the professional list below and release of the form and related information to RCT to be used for transportation purposes.

Signature_____ Date_____

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SECTION 2: To Be Completed by Health Care Professional

The following section of the application should be completed by a physician, optometrist, ophthalmologist, psychiatrist, physical or occupational therapist, low vision specialist or mobility specialist.

Applicant's Name _____

Address_____

Is this person able to travel without the assistance of another person for…

200 feet?	_____ yes	_____ no	_____ sometimes
¼ mile?	_____ yes	_____ no	_____ sometimes
¾ mile?	_____ yes	_____ no	_____ sometimes

Is this person able to climb stairs using handrails? _____ yes _____ no

Is this person able to wait outside without support for 10 minutes? _____ yes _____ no

For transportation purposes, does this person require the use of a wheelchair or walking aid ?
_____yes _____ no

Describe the aid _____

_____

For transportation purposes, dies this person require the use of a personal care attendant?
_____ yes _____ no _____ sometimes

Does weather affect this person's condition ? Describe_____

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Is this person able to :

-give address & telephone number on request? _____ yes _____ no
-recognize streets and bus numbers? _____ yes _____ no
-sign his or her name? _____ yes _____ no
-ask for and understand instructions? _____ yes _____ no
-be taught to use fixed route services? _____ yes _____ no

Describe this person's medical diagnosis related to the disabling condition

_____

_____

_____

_____

Is this condition temporary? _____ yes _____ no

Does the primary disability of this person prevent them from utilizing fixed route bus service?

_____ yes _____ no _____ sometimes

Are there other factors which, when combined with their primary disability, prevent the person from riding fixed route bus service? _____ yes _____ no _____ sometimes

If yes or sometimes, please explain:

_____

_____

_____

Name_____ Title _____

Office Address_____ Phone _____

Agency _____

Signature _____ Date _____

"CITY BUS SERVICE AT ITS BEST"