

Attached is an application to request certification of ADA Para-Transit eligibility. When the application is complete please forward to:

**COLUMBIA TRANSIT**  
**P.O. BOX 6015**  
**COLUMBIA, MO 65205-6015 , Fax 573-874-7276**

When a completed application is received by Columbia Transit a meeting will be scheduled with a representative from Columbia Transit in order to furnish information concerning the Para-transit Service. Meetings are held the First and Third Tuesdays of each month. Complimentary transportation will be provided to and from the meeting if needed.

If you have any questions, or would like assistance completing the form please feel free to contact the Transit Division of Public Works, Para-Transit at 874-7290, or [para-transit@www.GoColumbiaMo.com](mailto:para-transit@www.GoColumbiaMo.com)

**City of Columbia Appeal Process for Determination of Non-Eligibility  
for CT ADA Para-Transit Service**

Section 5.4 of the CT Para-Transit Plan states the City's policy on appeals:

If an individual is determined to be non-eligible for Para-Transit service, an appeal of the decision can be made to the City of Columbia Americans with Disabilities Act Coordinator located in the City Manager's Office. The period for appealing a determination of non-eligibility will be limited to 60 days. If after 30 days, the appeal has not been decided, the individual will be presumed eligible until a final decision is reached. The individual making the appeal has the right to be heard in person and to have the necessary support, such as a sign language interpreter.

All appeals must be made in writing and submitted to the ADA Coordinator. Please include your name, address, telephone number, and a brief explanation of the basis for your appeal. You are welcome to appear in person to present your appeal. If you plan to appear in person, please state if you have any special requirements, such as a sign language interpreter, so the City can make the appropriate arrangements when scheduling your appointment. Appeals should be addressed to:

**ADA Coordinator**  
**Attn: Human Resource Director**  
**P.O. Box 6015**  
**Columbia, MO 65205-6015**

If you need additional information or need assistance, contact Para-Transit at 874-7290.



**A. MOBILITY INFORMATION**

6. Mobility Information: Which of the mobility aids or equipment do you use to help you get where you need to go? ( Please check all that apply to you).

- G None
- G Cane
- G White Cane
- G Walker
- G Crutches
- G Manual Wheelchair
- G Powered Wheelchair

If you use a wheelchair what are the physical dimensions of the chair, including foot or head extensions (in inches) ?

\_\_\_\_\_Wide\_\_\_\_\_Length\_\_\_\_\_Height

**NOTE: The maximum weight our bus lift will hold safely is 600 pounds.**

**Maximum 32" width, 48" length, 56" height.**

- G Powered Scooter/Cart
- G Portable Oxygen
- G Service Animal
- G Picture Board
- G Alphabet Board
- G Other\_\_\_\_\_

If you were to ride the regular CT buses would you need someone with you?

- G Always
- G Sometimes
- G No

Have you ever had training to learn how to use a regular bus?

- G Yes
- G No

**B. DISABILITY OR HEALTH CONDITION INFORMATION**

( Please indicate all conditions which affect your ability to use the bus.)

The disability that prevents me from using the CT fixed route buses

is \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is this condition temporary? Yes\_\_\_\_\_No\_\_\_\_\_

If Yes, expected duration until \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Please mark all categories below as they relate to your disability.

7. Do you ride the regular CT fixed route bus?

\_\_\_\_\_yes\_\_\_\_\_no

8. Are you able to independently maneuver on or off a wheelchair lift?

\_\_\_\_\_yes\_\_\_\_\_no

9. Are you able to identify the correct bus?

\_\_\_\_\_yes\_\_\_\_\_no

10. How does this disability prevent you from using fixed route bus service? Please explain completely.  
Use an additional sheet if necessary. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. Are there any other effects of your disability of which we need to be aware? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. The disability that prevents me from using the CT fixed route buses would place me in the following Category

\_\_\_\_\_ I am unable to ride the CT bus without the assistance of someone else.

\_\_\_\_\_ The bus stop is not accessible due to lack of sidewalks or curb cuts.

\_\_\_\_\_ My disability prevents me from getting to and from the bus stop.

\_\_\_\_\_ My disability does not prevent me from riding the CT buses.

13. Are you legally blind? ( Legally blind is defined as: The visual acuity in your best eye with best Correction is no better than 20/20, or the vision field of the best eye is constricted to less than 20 degrees.)

\_\_\_\_\_ YES \_\_\_\_\_ NO

Visual Acuity: \_\_\_\_\_ Right eye \_\_\_\_\_ Left eye \_\_\_\_\_

14. Do you have limited vision?

\_\_\_\_\_ YES \_\_\_\_\_ NO

15. Are you able to handle/grasp coins (pay fare), tickets, railings, and handles?

\_\_\_\_\_ YES \_\_\_\_\_ NO

16. Are you able to keep balance while seated on a moving vehicle?

\_\_\_\_\_ YES \_\_\_\_\_ NO

17. Do you travel with a Personal Attendant with you when using the bus? Yes \_\_\_\_\_ No \_\_\_\_\_

18. Please answer the following questions.

Indicate if you walk or use a mobility aid:

Walk \_\_\_\_\_ Mobility Aid \_\_\_\_\_

Can you travel 200 feet without assistance from another person?

Yes \_\_\_\_\_ No \_\_\_\_\_ Sometimes \_\_\_\_\_

Can you travel 1/4 mile without assistance from another person?

Yes \_\_\_\_\_ No \_\_\_\_\_ Sometimes \_\_\_\_\_

Can you travel 3/4 mile without assistance from another person?

Yes \_\_\_\_\_ No \_\_\_\_\_ Sometimes \_\_\_\_\_

Can you climb three 12 inch steps without handrails or assistance?

Yes \_\_\_\_\_ No \_\_\_\_\_ Sometimes \_\_\_\_\_

If you use a wheelchair or power scooter, can you use the wheelchair lift and board a CT bus?

Yes \_\_\_\_\_ No \_\_\_\_\_

Can you wait outside, without support, for ten minutes?

Yes \_\_\_\_\_ No \_\_\_\_\_ Sometimes \_\_\_\_\_

Can you communicate with a bus driver yourself or with the help of an aid (such as a letter board)?

19. Does your ability to perform the aforementioned tasks depend upon conditions such as location, terrain, climate, or weather?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain the conditions: \_\_\_\_\_

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

20. Are you able to give address and telephone numbers upon request?

YES \_\_\_\_\_ NO \_\_\_\_\_

21. I hereby certify that the information given above is correct. I understand that falsification of information may result in denial of service. I understand all information will be kept confidential, and only information required to provide the services I requested will be disclosed to those who perform those services. I understand that the City Transit may contact the health care professional who has completed the professional verification section of this application in order to confirm this information.

**(Applicant's signature)**

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

In order to allow the City of Columbia to evaluate your request, this professional verification section must be completed. **Please contact a physician or other professional to confirm the information you have provided. THIS PORTION MUST BE COMPLETED BY ONE OF THE FOLLOWING RECOGNIZED PROFESSIONS: registered nurse, physician, psychologist, nurse practitioner, physician's assistant, employed by a medical facility.** Please complete the following information and authorization form.

The applicant may be found eligible for Para-Transit curb-to curb bus services for all trips he/she requests (based on functional ability) or capable of using the regular bus. NOTE: All fixed route buses are equipped with a lift for people who use a wheelchair or cannot climb stairs.

The information you provide will enable us to make an appropriate determination for each trip request. All information will be kept confidential. Thank you for your assistance.

**PROFESSIONAL VERIFICATION FOR** \_\_\_\_\_  
**Print Patient's Name**

**Required Information:** (Failure to provide information may cause a delay in application processing.)

Please fill in the type of disability.

The patient's disability, which is \_\_\_\_\_, qualifies the applicant for curb-to-curb Para-Transit Service.

Please explain how this disability prevents use of regular wheel chair equipped fixed buses.

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

**Medical facility health care professional is associated with:** \_\_\_\_\_

Address \_\_\_\_\_

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

Phone Number \_\_\_\_\_

**Printed name and title is a requirement for the processing of this application.**

**Print Name and Title** \_\_\_\_\_

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

(Must be signed by the physician or recognized professional )