



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**

After receiving a complete application, applicants may receive 21 days of complimentary Para transit service. 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. Failure to attend a scheduled meeting will result in denial of service until the requirement is made. If a meeting is not scheduled within the 21 days, the applicant will be “presumed eligible”, until a meeting is held.

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.

**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: Tony St. Romaine
701 E. Broadway
Columbia, MO 65205-6015**

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

REQUEST FOR CERTIFICATION OF ADA PARA-TRANSIT ELIGIBILITY

The information obtained in this certification process will only be used by the City of Columbia for the provision of transportation services. Information will only be shared with other transit providers to facilitate travel in those areas. The information will not be provided to any other person or agency.

1. Last Name _____ First Name _____ Initial _____
2. Address _____
City _____ State _____ Zip Code _____
3. Telephone Number (Home) _____ (Work) _____
4. Date of Birth ____/____/____ 5. Gender: Female _____ Male _____
5. Social Security Number ____-____-_____

TRANSIT DEPARTMENT USE ONLY

_____ **New Application** WC _____ AMB _____

_____ **Renewal Application** **DISABILITY CODE** _____

Card # _____

Date Issued _____

Expiration Date _____

6. In the event of a situation requiring outside assistance or a medical emergency, who in the local area should be contacted?

Name _____ Phone Number _____

Relationship to Applicant _____

Specific Instructions, if any: _____

A. MOBILITY INFORMATION

7. 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).

- None
- Cane
- White Cane
- Walker
- Crutches
- Manual Wheelchair
- Powered Wheelchair
- Powered Scooter/Cart
- Portable Oxygen
- Service Animal
- Picture Board
- Alphabet Board
- Other _____

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

_____Wide _____High _____Long

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

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

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

- Always
- Sometimes
- No

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

- Yes
- 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.

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

_____yes _____no

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

_____yes _____no

10. Are you able to identify the correct bus?

_____yes _____no

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

12. Are there any other effects of your disability of which we need to be aware? _____

13. 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.

14. Are you legally blind? (Legally blind is defined as: The visual acuity in your best eye with best Correction is no better than 20/220, or the vision field of the best eye is constricted to less than 20 degrees.)

_____ YES _____ NO

Visual Acuity: _____ Right eye _____ Left eye _____

15. Do you have limited vision?

_____ YES _____ NO

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

_____ YES _____ NO

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

_____ YES _____ NO

18. Do you travel with a Personal Attendant with you when using the bus? Yes _____ No _____

19. 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)?

20. 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: _____

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

YES _____ NO _____

22. 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 _____ / _____ / _____

If this application was prepared by someone other than the applicant, please sign above and provide the information below:

Name: _____, Address _____,
City _____, State _____, Zip Code _____, Phone Number _____,
Relationship _____.

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 or ramp 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 the application process.)

The applicant's disability, is _____.

Professional's Information (Please Print):

Medical Professional Associated With: _____

Name _____

Title _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____

Signature below indicates that I certify that the above named individual is unable to ride on the standard fixed route transit system and should be eligible for the Para-Transit Service.

Signed _____ **Date** ____/____/____
(Must be signed by the physician or recognized professional)