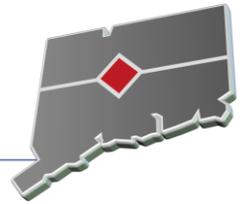


# **CENTRAL CONNECTICUT** PARATRANSIT

*Providing transportation for the disabled in central Connecticut*

225 North Main Street, Suite 304, Bristol, CT 06010 · tel/fax: 860-589-6950 · <http://busoncall.com>



Dear Applicant,

ADA paratransit service is for individuals who are unable, because of a disability, to use the fixed route bus system for some or all of their trips. The paratransit service must provide a level of service that is comparable to what is provided by the fixed route system. Accordingly, the paratransit service operates in the same area as the fixed route system (within  $\frac{3}{4}$  mile of the fixed route system); operates the same days and hours as the fixed route system; provides trips for any purpose; provides next day service; and charges comparable fares (no more than twice the public bus fare).

To be considered for ADA paratransit service, you must complete the enclosed application and medical form. There are five medical forms enclosed. Please locate the form that is most applicable to you. This form must be completed by a licensed health care professional most familiar with your disability (see reverse for detailed instructions). Please retain a copy for your records.

Once you have completed the application form and have received a completed medical form from a professional, please send to:

Central Connecticut Regional Planning Agency  
Attn: Paratransit Service  
225 North Main Street, Suite 304  
Bristol, CT 06010

Upon receipt of your application and medical form, you may be contacted for an interview. Please note we have up to twenty-one (21) days from receipt of a completed application to make a determination. All applicants will be notified in writing of the eligibility determination.

There are three classes of paratransit eligibility granted. Unconditional eligibility is granted if individuals are unable to make any trip using the fixed route system. Conditional eligibility is granted if individuals can sometimes use the fixed route system but other times may need the paratransit service. Temporary eligibility is granted for the period of time that a disabling condition is expected to last.

Please contact me at (860) 589-6950 with any questions. Residents of Berlin and New Britain without toll-free long distance may call (860) 348-5610.

Regards,

Abigail St. Peter  
Assistant Planner

## **Instructions for Completing Medical Form**

1. There are five medical forms included in this packet. Find the form that is most applicable to you. You may choose from the form for applicants with:

- Cognitive disabilities
- Physical disabilities
- Psychiatric disabilities
- Seizure disorders
- Vision Disabilities

If you have multiple disabilities, you may choose to submit a form for each one.

2. Once you have selected the appropriate form, you must have the form completed by a licensed health care professional. Please contact the professional that is most familiar with your disability.

3. Request that the professional return the form to you.

4. Once you have received the completed form from the professional, place the form in an envelope along with the application.

5. Send the completed application packet to the Central Connecticut Regional Planning Agency.

Your application will not be considered complete until we have received both your application and medical verification.

## Request for Paratransit Eligibility Certification under the Americans with Disabilities Act

If you are completing this form on a computer, click "Submit" on the last page to return it by e-mail. You may also return it to CCRPA, ATTN: Paratransit Application, 225 North Main St., Suite 304, Bristol, CT 06010-4993 or fax it to (860) 589-6950. If you have any questions, please call us at (860) 589-7820 or (860) 348-5610.

ALL QUESTIONS MUST BE COMPLETELY ANSWERED.  
INCOMPLETE APPLICATIONS WILL BE REJECTED.

### *Certification*

*Please read the following paragraph and sign below. (Typed signatures are acceptable.)*

I understand that the purpose of this application is to determine if there are times when I cannot use the public city buses (CTTransit) and must therefore use the ADA Paratransit Service. I understand that any information about my disability in this application will be kept confidential and shared only with professionals involved in providing this service. I certify that, to the best of my knowledge, the information in this application is true and correct. I understand that providing false or misleading information may result in re-evaluation of my eligibility.

Signature of applicant/guardian \_\_\_\_\_ Date \_\_\_\_\_

### *Your contact information*

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address \_\_\_\_\_ Apt./Bldg. # \_\_\_\_\_

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

Is this a temporary residence?  Yes  No

Is this a Licensed Nursing Care Facility?  Yes  No

If yes, name of facility \_\_\_\_\_

Date of Birth (MDY) \_\_\_/\_\_\_/\_\_\_

Sex  Male  Female

Telephone (daytime) \_\_\_\_\_ (evening) \_\_\_\_\_

TDD/Relay # (if applicable) \_\_\_\_\_

*Please give us the name and telephone number of someone we can call in an emergency or if we are unable to reach you at your regular number:*

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone (home) \_\_\_\_\_ (work) \_\_\_\_\_

Agency (if applicable) \_\_\_\_\_

*If someone assisted you in completing this application, please provide us with that person's name and telephone number below:*

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone (home) \_\_\_\_\_ (work) \_\_\_\_\_

Agency (if applicable) \_\_\_\_\_

How did you hear about our services? \_\_\_\_\_

## ***Your public bus experience***

1. *Do you ride the public city bus (CTTransit)?*

Yes  No  Sometimes

2. *When was the last time you used the public city bus (CTTransit)?*

\_\_\_\_\_

3. *Could you use the public city bus (CTTransit) if you had information on routes and times?*

Yes  No  Sometimes

4. *Travel Training is a free service that assists people with disabilities to learn how to ride and use the public city bus (CTTransit) service. Would you like more information?*

Yes  No  I need information in accessible formats

5. *Are you eligible to use medical or other transportation services?*

*(e.g., Medicaid, Social Services, etc.)*

Yes  No  Don't Know

## Your functional ability

Can you get on and off a public city bus (CTTransit)?

Yes, I can climb steps

I probably could with instruction

Yes, I can use the lift and/or ramp

No (explain) \_\_\_\_\_

For each statement, check one answer. Your answer should be based on how you feel most of the time under normal circumstances and whether you can perform this activity.

I can cross the street if there are curb cuts.

Yes

No

Sometimes

I can travel up/down a gradual hill in good weather conditions.

Yes

No

Sometimes

I can find my way to the public city bus (CTTransit) stop if someone shows me once.

Yes

No

Sometimes

I am able to wait for 10 minutes at a public city bus (CTTransit) stop that does not have seats and a shelter.

Yes

No

Sometimes

I am able to ask for, understand, and follow directions.

Yes

No

Sometimes

I am able to detect curbs, ramps, and other drop off areas.

Yes

No

Sometimes

Answer the following questions by checking all that apply. What barriers in your surroundings make it difficult for you to use the public city bus (CTTransit)?

- |   |  |
|---|--|
| <input type="checkbox"/> Lack of curb cuts      | <input type="checkbox"/> Sidewalks are in poor condition |
| <input type="checkbox"/> No sidewalks           | <input type="checkbox"/> Busy streets I must cross       |
| <input type="checkbox"/> Steep hills            | <input type="checkbox"/> No crosswalks at street corners |
| <input type="checkbox"/> Other (describe) _____ |  |

## Your medical condition

What type of disability prevents you from using the public city bus (CTTransit) system?  
Check all that apply.

- |                                   |  |
|-----------------------------------|--|
| <input type="checkbox"/> Physical | <input type="checkbox"/> Cognitive     |
| <input type="checkbox"/> Visual   | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Hearing  | <input type="checkbox"/> None          |
| <input type="checkbox"/> Other    |  |

Identify disabilities by name \_\_\_\_\_

Please describe your disability in detail \_\_\_\_\_

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Is this condition temporary?  Yes  No

If yes, expected duration \_\_\_\_\_

Do you require the assistance of a Personal Care Attendant (PCA)?

- Yes  No  Sometimes

Do you use any of the following devices? Check all that apply.

- |                                     |   |   |
|-------------------------------------|---|---|
| <input type="checkbox"/> Cane       | <input type="checkbox"/> Manual wheelchair*   | <input type="checkbox"/> Oxygen tank    |
| <input type="checkbox"/> Crutches   | <input type="checkbox"/> Electric wheelchair* | <input type="checkbox"/> Service animal |
| <input type="checkbox"/> Braces     | <input type="checkbox"/> Power scooter*       | <input type="checkbox"/> None           |
| <input type="checkbox"/> Walker     | <input type="checkbox"/> Communication board  |   |
| <input type="checkbox"/> White cane |   |   |

## **Authorization to obtain physician/other professional verification**

*In order to evaluate your request, it may be necessary to contact your physician or other professional to confirm the information you have provided. Please complete the following information and authorization form.*

Physician       Health Care Professional       Rehabilitation Professional

*The following professional is familiar with my disability and is to provide the required needed information to the Central Connecticut Paratransit Service to complete my certification for ADA Paratransit Service.*

Professional's Name \_\_\_\_\_

Agency or Practice \_\_\_\_\_

Office Address \_\_\_\_\_

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

Professional's Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Applicant's Name \_\_\_\_\_ Date of Birth (MDY) \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of applicant/guardian \_\_\_\_\_ Date \_\_\_\_\_

*If you cannot submit this application with the button below, please save this PDF to disk and attach it to an e-mail to [apply@busoncall.com](mailto:apply@busoncall.com).*

### **Definition of ADA Regulations**

Any person with a disability who is unable, as a result of a physical or mental impairment, and without the assistance of another individual, (except the operator of a wheelchair lift) to board, ride, or disembark from any public city bus. Any person with a disability who has a specific impairment-related condition which prevents them from traveling to or from a bus stop on the public city bus system. Architectural and environmental barriers such as distance, terrain or weather; do not, standing alone, form a basis for eligibility. However, a person may be eligible if the interaction of the disability and barriers prevent the person from traveling to or from the public city bus stop.

\* A common wheelchair is any device that has three or four wheels operated manually or powered. It should not exceed 30 inches in width, 48 inches in length, and 600 pounds when occupied and certified for use.

MEDICAL VERIFICATION FORM FOR APPLICANTS WITH  
**COGNITIVE DISABILITIES**

**Patient name:**

**Date of visit:**

MEDICAL PROVIDER

**Name and signature of healthcare professional:**

**Telephone number:**

**Medical provider or facility:**

PATIENT INFORMATION

DIAGNOSIS

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Does the patient have a cognitive disability? If so, please describe.

**Response:**

Does the patient have behavioral problems? If so, please describe.

**Response:**

PROFESSIONAL OPINION OF PATIENT'S ABILITIES

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Is the patient able to follow directions and navigate in public on her/his own?  
(If not, what accommodations are necessary to enable the patient to do so?)

**Response:**

Is the patient able to get help if s/he is lost? Please describe any limitations.

**Response:**

Is the patient able to recognize and avoid dangerous situations?  
Please describe any limitations.

**Response:**

Is the patient able to cross a street safely?

**Response:**

Is the patient able to understand time and keep appointments?  
(If not, what accommodations are necessary to enable the patient to do so?)

**Response:**

In your opinion, do the patient's disabilities make it impossible or unsafe for her/him to take a city bus? (This includes traveling to/from stops or stations, hailing/halting buses, entering/exiting vehicles, and transferring.)

**Response:**

Additional comments.

**Response:**

MEDICAL VERIFICATION FORM FOR APPLICANTS WITH  
**PHYSICAL DISABILITIES**

**Patient name:**

**Date of visit:**

MEDICAL PROVIDER

**Name and signature of healthcare professional:**

**Telephone number:**

**Medical provider or facility:**

PATIENT INFORMATION

DIAGNOSIS

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Does the patient have a physical disability? If so, please describe.

**Response:**

What is the prognosis for this disability?

**Response:**

PROFESSIONAL OPINION OF PATIENT'S ABILITIES

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How does the patient's disability affect daily life activities?

**Response:**

Is the patient able safely to complete the following tasks?  
Please describe any limitations.

**Response:**

Task	Able to complete?	Limitations
Walk/wheel to/from a bus stop on a road or sidewalk		
Wait at a bus stop		
Hail/halt a bus		
Enter/exit a bus		
Negotiate steps/curbs		
Cross a street		
Ascend/descend slopes		

Do any environmental conditions pose a challenge or a danger to the patient?  
(These include changes in terrain, such as steep grades; slippery or uneven surfaces such as snow/ice, mud, gravel, substandard sidewalks or roads; and atmospheric conditions such as temperature, humidity, and air quality.) If so, please describe.

**Response:**

In your opinion, do the patient's disabilities make it impossible or unsafe for her/him to take a city bus? (This includes traveling to and from bus stops and transferring.)

**Response:**

Additional comments.

**Response:**

MEDICAL VERIFICATION FORM FOR APPLICANTS WITH  
**PSYCHIATRIC DISABILITIES**

**Patient name:**

**Date of visit:**

MEDICAL PROVIDER

**Name and signature of healthcare professional:**

**Telephone number:**

**Medical provider or facility:**

PATIENT INFORMATION

DIAGNOSIS

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Does the patient have a psychiatric disability? Is s/he being medicated for this disorder?  
Please describe.

**Response:**

What is the prognosis for this disability?

**Response:**

Does the patient have behavioral problems? If so, please describe.

**Response:**

PROFESSIONAL OPINION OF PATIENT'S ABILITIES

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Is the patient able to follow directions and navigate in public on her/his own?  
(If not, what accommodations are necessary to enable the patient to do so?)

**Response:**

Is the patient able to recognize and avoid dangerous situations?  
Please describe any limitations.

**Response:**

Is the patient able to understand time and keep appointments?  
(If not, what accommodations are necessary to enable the patient to do so?)

**Response:**

In your opinion, do the patient's disabilities make it impossible or unsafe for her/him to take a city bus? (This includes traveling to and from bus stops and transferring.)

**Response:**

If the patient stopped taking her/his medication, would it change your answers to the above questions? If so, please describe.

**Response:**

Additional comments.

**Response:**

MEDICAL VERIFICATION FORM FOR APPLICANTS WITH  
**SEIZURE DISORDERS**

**Patient name:**

**Date of visit:**

MEDICAL PROVIDER

**Name and signature of healthcare professional:**

**Telephone number:**

**Medical provider or facility:**

PATIENT INFORMATION

**DIAGNOSIS**

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Does the patient have a seizure disorder? Is s/he being medicated for this disorder?  
Please describe.

**Response:**

How often do seizures occur? Are they triggered by anything? Please describe.

**Response:**

What is the prognosis of this disorder?

**Response:**

PROFESSIONAL OPINION OF PATIENT'S ABILITIES

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Is the patient able safely to travel alone in the community?

Please describe any limitations.

**Response:**

Is the patient able to recognize and avoid situations that could induce a seizure?

Please describe any limitations.

**Response:**

In your opinion, does the patient's disorder make it impossible or unsafe for her/him to take a city bus? (This includes traveling to and from bus stops and transferring.)

**Response:**

If the patient stopped taking her/his medication, would it change your answers to the above questions? If so, please describe.

**Response:**

Additional comments.

**Response:**

MEDICAL VERIFICATION FORM FOR APPLICANTS WITH  
**VISION DISABILITIES**

**Patient name:**

**Date of visit:**

MEDICAL PROVIDER

**Name and signature of healthcare professional:**

**Telephone number:**

**Medical provider or facility:**

PATIENT INFORMATION

DIAGNOSIS

---

Does the patient have a vision disability? If so, please describe.

**Response:**

Is the patient's vision affected by different lighting conditions? If so, please describe.

**Response:**

What is the prognosis for this disability?

**Response:**

PROFESSIONAL OPINION OF PATIENT'S ABILITIES

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How does the patient's disability affect daily life activities?

**Response:**

Is the patient able safely to complete the following tasks?  
Please describe any limitations.

**Response:**

Task	Able to complete?	Limitations
Walk/wheel to/from a bus stop on a road or sidewalk		
Hail/halt a bus		
Enter/exit a bus		
Negotiate steps/curbs		
Cross a street		
Ascend/descend slopes		

Do any environmental conditions pose a challenge or a danger to the patient?  
(These include changes in terrain, such as steep grades; slippery or uneven surfaces such as snow/ice, mud, gravel, substandard sidewalks or roads; high background noise levels; and high traffic volumes or speeds.) If so, please describe.

**Response:**

In your opinion, do the patient's disabilities make it impossible or unsafe for her/him to take a city bus? (This includes traveling to/from stops or stations, hailing/halting buses, entering/exiting vehicles, and transferring.)

**Response:**

Additional comments.

**Response:**