Massachusetts Americans with Disabilities
Paratransit Application Form

Please note that any information given on this application will be kept confidential and shared only with professionals involved in providing the paratransit service on an as needed basis.

THIS APPLICATION WILL BE ACCEPTED AT THE REGIONAL TRANSIT AUTHORITIES LISTED IN ATTACHMENT A

A. Personal Information		
Last Name:	First Name:	
Date of Birth:	Preferred Name:	
B. Current Residence		
Street Address (include building, apartment or room number information):		
City:	State:	Zip:
Is this residence:		
☐ Single Family House	☐ Multifamily House	
☐ Apartment or Condominium Complex	Name:	
☐ Nursing or Assisted Living Facility	Name:	
☐ College or University	Name:	
Other:		
Is this a temporary residence: ◯ Yes ◯ No		
C. Mailing Address (if different from residence)		
Street Address (include building, apartment, or room number information): ☐ (check here if same as above)		
City:	State:	Zip:
D. Contact Information		
Primary Phone:	Alternate Phone:	
Email Address (optional):		
Preferred method of communication:		
◯ Phone	◯ Email	◯ Mail ◯ Text (if available at RTA)
Preferred Language:		
E. Emergency Contact		
Last Name:	First Name:	
Relationship:	Agency (if Applicable):	
Primary Phone:	Alternate Phone:	

F. If someone assisted you in completing this form, please give the following information:	
Last Name:	First Name:
Relationship:	Agency (if Applicable):
Primary Phone:	Alternate Phone:
May we contact this person with questions regarding your application? ◯ Yes ◯ No	

G. General Information About Your Disability				
Please indicate below if you need ADA service information in the following accessible formats:				
☐ Large Print	☐ Audio	☐ Braille	☐ Email	Other:

Are you certified for ADA Paratransit services by another service provider or transit agency:
◯ Yes ◯ No

If yes:	Name of Service Provider:	State:

Please list the diagnosis' that prevent you from using the fixed route bus service:

_____.

_____.

_____.

_____.

Explain how your diagnosis prevents you from independently using the fixed route bus service:

Is the disability or health related condition you describe:

☐ Permanent	If permanent is level of ability expected to change ◯ Yes ◉ No
☐ Temporary	If temporary how log is it expected to last:
☐ Unsure	

Does your health condition or disability change from day to day in a way that affects your ability to use the fixed route bus service? ◯ Yes ◯ No ◯ Sometimes

If "Yes" or "Sometimes", Please explain:

Are there times when someone accompanies you when you travel?
◯ Yes ◯ No ◯ Sometimes

Do you use any of the following devices when you travel?

☐ Manual Wheelchair*	☐ Powered Wheelchair*	☐ Scooter*
☐ Walker	☐ Cane	☐ Long White Cane
☐ Oxygen	☐ Communication Device	☐ Crutches
☐ Service Animal	☐ Respirator	☐ Other:

*The term wheelchair refers to any three or more wheeled device which is usable indoors. We will be able to accommodate a wheelchair if (1) the lift and vehicle can physically accommodate it and (2) if it is consistent with legitimate safety requirements. Legitimate safety requirements include but are not limited to such circumstances as a wheelchair of such size that it would block an aisle or would interfere with safe evacuation of passengers in an emergency, and/or is overweight when occupied for the vehicle specifications.

H. Fixed Route Bus Service Experience

Have you ever ridden the fixed route bus?

Yes ◯	How often and to what locations?
	If not currently riding, why?

Some providers have Travel Training, which is a free service that teaches people how to use the fixed route bus. If this is available in your area, would you be interested in receiving more information? ◯ Yes ◯ No

I. Functional Ability

Can you find your way to a public bus stop if someone shows you once?
◯ Yes ◯ No ◯ Sometimes

How far can you safely walk (using a mobility aid if necessary)? _____ Feet _____ Blocks

Can you walk up/down a gradual hill? ◯ Yes ◯ No ◯ Sometimes

Can you see/detect curbs, ramps, and other drop off areas? ◯ Yes ◯ No ◯ Sometimes

How long can you stand and wait at a fixed route bus stop? _____ minutes

Can you recognize and request stops when on the bus? ◯ Yes ◯ No ◯ Sometimes

Can you physically get on and off a fixed route bus? All RTA vehicles have lifts, ramps, or the ability to kneel and are accessible. ◯ Yes ◯ No ◯ Sometimes

If "No" or "Sometimes", please explain:

Can you ask for, understand, and follow travel directions? ◯ Yes ◯ No ◯ Sometimes

If "No" or "Sometimes", please explain:

J. Barriers		
What environmental barriers make it difficult for you to use the fixed route bus service?		
☐ Lack of curb cuts/ramps	☐ Steep hills	☐ No sidewalks
☐ Busy street I must cross	☐ No crosswalk light/vocal indicator	☐ Sidewalks in poor condition
☐ Snow/Ice on Ground	☐ Other (describe):	
Explain why the conditions you indicated make it difficult:		

K. Applicant Acknowledgement	
By signing below, you certify that the information submitted on this application is true to the best of your knowledge.	
Applicant Signature:	Date:
If an applicant cannot sign their name, the legal guardian must sign on their behalf:	
Legal Guardian Signature:	Date:

MEDICAL INFORMATION RELEASE AUTHORIZATION

For an RTA to evaluate your request they will need to contact a medical/clinical professional to confirm the information you provided. Please complete the following information and authorization form.

The following Licensed Health Care Professional is familiar with my disability and is authorized to provide the RTA with all information required to complete this certification.

Licensed Professional's Information		
Name:	Agency/Facility:	
Mailing Address:		
City:	State:	Zip
Professional Certification:		
☐ Physician	☐ Nurse Practitioner	☐ Physician Assistant
☐ Psychiatrist	☐ Licensed Social Worker	☐ Neurologist
☐ Occupational Therapist	☐ Physical Therapist	☐ Physician Assistant
☐ Other:		
I hereby authorize the professional listed above to release any information necessary to determine Paratransit eligibility to the: (*Enter Name of RTA*)		
Applicant Signature:		Date:
Printed Name:		

REQUEST FOR PROFESSIONAL VERIFICATION

The patient indicated that you could provide information regarding their disability and its impact upon their ability to utilize public transit services. Federal law requires that Regional Transit Authorities provide paratransit services to persons who cannot use available accessible fixed-route bus services. ***(Fixed-route services are transit services where vehicles run on regular, scheduled routes with fixed stops. For example, a city bus that always travels the same route is part of the fixed- route system.)*** Please keep in mind that any condition which makes traveling to or from a boarding/disembarking location or riding on a fixed-route system more difficult or less comfortable, are not reasons for paratransit eligibility. The information you provide will let us evaluate the request and its application to specific trip requests.

Applicant/Patient Name: _____ Date of Birth:_____

Information Regarding Applicant's Functional Abilities			
Medical/clinical diagnosis of condition causing disability:			
Explain how the applicant's disabilities or health related conditions could prevent them independently using the fixed route bus service:			
Is the disability or health related condition:			
Permanent ☐	If permanent is it expected to change	◯ Yes	◯ No
Temporary ☐	Expected to last:		
Unsure ☐			
Does the health condition or disability change from day to day in a way that affects their ability to use the public bus service?	◯ Yes	◯ No	◉ Sometimes
If "Yes" or "Sometimes", Please explain (for example: extreme temperatures, medication side effects, etc.):			
Does the applicant require a Personal Care Attendant to complete daily tasks? ◯ Yes ◯ No ◯ Sometimes			
I certify that I have completed the questions in this Professional Verification Form and that the information provided is correct to the best of my knowledge			
Signature of Health Care Provider:			
Printed Name:		Date:	
License #		Date of Expiration:	