Brazos Transit District

ADA Paratransit Transportation Application

PART A and PART B must be completed and submitted together in order to process the application.

Office Use ONLY: ☐ Approved ☐ Denied
Date: ______________Client: _________

PART A: To be completed by applicant or on behalf of the applicant.

PLEASE PRINT

Date: ____________________ Gender: ☐ Male ☐ Female

Name: Last: ________________________ First: ________________________MI: _______

Residence Street Address: ____

Apt No: __________________ Is the apartment complex gated: Yes____ No____

City: __________________________ State: _________ Zip: ________________

Mailing Address (if different): ____

____

Date of Birth: __________________ Home Phone: _______________________

Cell Phone: ____________________ Work Phone: ________________________

APPLICANT EMERGENCY CONTACTS:

Primary Contact:

Name: ____

Relationship: ____

Address: ____

Home Phone: _________________Cell Phone: _________________________

Secondary Contact:

Name: ____

Relationship: ____

Address: ____

Home Phone: _________________Cell Phone: _________________________

APPLICANT INFORMATION:

1. Are you a: ☐ Current ADA Paratransit Rider ☐ New Applicant

2. Which of the following condition(s), if any, prevent you from using the Fixed Route system (city buses) in Bryan/College Station, Lufkin, Nacogdoches, The Woodlands Township, or Liberty/Dayton/Ames?

- ☐ None
- ☐ Physical
- ☐ Visual
- ☐ Mental Illness
- ☐ Brain Injury
- ☐ Deaf
- ☐ Intellectual Disability
- ☐ Other ______

3. Briefly explain how your disability prevents you from using the fixed route buses (city buses).

____

____

____

4. Is your disability or health condition: ☐ Permanent ☐ Temporary?

If temporary; expected to last until: ____________________________________

5. Please indicate the primary mobility aid you use when traveling in the community:

- ☐ Manual Wheelchair
- ☐ Wheeled Walker
- ☐ Blind
- ☐ Cane
- ☐ Foldable Wheelchair
- ☐ Foldable Walker
- ☐ Segway
- ☐ Crutches
- ☐ Power Wheelchair
- ☐ Service Animal
- ☐ Hearing Device
- ☐ Leg Braces
- ☐ Scooter
- ☐ Oxygen Tank
- ☐ Prosthesis
- ☐ Other_____________________

***Note**: The ADA (Americans with Disabilities Act) states that a transportation provider may decline to carry a mobility device/occupant if the combined weight exceeds that of the lift specifications set by the manufacturer, or if the carriage of the mobility device is demonstrated to be inconsistent with legitimate safety requirements. BTD will transport all mobility devices that meet the vehicle manufacturer limits, which states that BTD may not be able to accommodate mobility devices longer than 48" or wider than 30" or weigh more than 800 pounds.*

6. Can you climb ten steps with a handrail, without assistance from another person?

☐ YES ☐ NO

If no, why not?____

7. If applicant has a disability affecting mobility, please indicate what distance you are able to travel without the assistance of another person.

☐ less than 200 ft. ☐ 5 to 6 blocks

☐ 1 to 2 blocks ☐ 7 to 8 blocks

☐ 3 to 4 blocks ☐ 9 or more blocks

8. Do you travel with a Personal Care Attendant (PCA)?

☐ YES ☐ NO ☐ Sometimes

9. Have you ever used the fixed route service (city buses)?

☐ YES ☐ NO

10. If YES, why are you no longer able to use the fixed route city buses?

____

____

11. If you have a cognitive disability, are you able to: (check all that apply)

☐ Give name, address and telephone numbers upon request?

☐ Recognize a destination or landmark?

☐ Deal with unexpected situation or unexpected changes in routine?

☐ Ask for, understand, and follow directions?

☐ Safely and effectively travel through crowded and/or complex facilities?

Explain:____

____

12. Describe your neighborhood: (check all that apply)

☐ Sidewalks in front of your residence.

☐ Wheelchair ramps at your residence.

☐ Paved road in front of your residence.

☐ Unpaved road in front of your residence.

ACKNOWLEDGEMENT

I agree to pay the exact fare for each trip. I agree to notify Brazos Transit District of any changes in my mobility status, which may affect my eligibility to use the service. I also understand that failure to adhere to the policies and procedures will be grounds for suspending or revoking my application and right to use the Brazos Transit District ADA Paratransit service. I understand and agree to hold Brazos Transit District harmless against all claims or liability for damages to any person, property, or personal injury occurring as a result of my failure to equip or maintain the safety measures of the adaptive equipment or service animal that I require for mobility. I understand that providing false and misleading information could result in my eligibility status being terminated. I have read and fully understand the conditions for service outlined above and agree to abide by them.

To the Applicant: I give permission for Brazos Transit District staff to contact the professional who has filled out this application or given supplemental verification of my condition. Sign below to allow the release of information from the professional who will be filling out this form. I hereby request that information pertaining to limitations that prevent me from using fixed route buses be released to Brazos Transit District for further determination of my ADA Paratransit eligibility.

Print Name: ____

Applicant's Signature:_______________________Date: _____________

If someone other than the person requesting certification has completed this application form, please complete the following:

Print Name: ____

Relationship to Applicant: _______________Day Phone: ____________

Address: ____

City: ___________________________State: ________ Zip: _________

Agency Name (If applicable):_______________________________

Signature: ___________________________Date: _________________

PART B: TO BE COMPLETED BY A MEDICAL PROFESSIONAL ONLY

PART A and PART B must be completed and submitted together in order to process the application.

Health Care Professional:

The applicant is asking you to review the information on this application and to complete and sign part B of this form certifying that they have a disability that prevents them from using fixed route buses (city buses) in Bryan/College Station, Nacogdoches and Lufkin. This information will be used to help determine whether or not the applicant needs to use ADA Paratransit (origin to destination) service or is able to use fixed route service for their travel needs.

To be completed by a medical professional who is knowledgeable about the applicant's functional ability.

We need to know the limitation/s of their disability that limits their ability to ride the fixed route bus. The following is necessary for us to process this applicant's request:

- Thorough details of the applicant's functional limitations, and how they inhibit that person's ability to board and use a fixed route bus.
- Thorough details of the applicant's cognitive limitations, and how they inhibit that person's ability to navigate using a fixed route bus.
- Thorough details of the applicant's physical limitation, and how they inhibit that person's ability to reach a bus stop or the destination from a bus stop.

Under the Americans with Disability Act (ADA), if a person has the functional capability to use Brazos Transit District's fixed route buses, that person is not eligible for ADA Paratransit service (origin to destination). Disability alone and distance to and from a bus stop, by itself, does not qualify a person for Brazos Transit District's ADA Paratransit Service.

Thank you for your assistance. If you have any questions while completing this form, please feel free to contact Brazos Transit District at (979)778-4480 or (800)272-0039.

Name of Patient/Applicant: ____

Date of Birth: _________________

TO BE COMPLETED BY A MEDICAL PROFESSIONAL ONLY

This form must be filled out by a professional who is knowledgeable about the applicants' disability and their limitations. Please check the appropriate box regarding the person completing this form:

- ☐ Vocational Rehab. Counselor
- ☐ O & M Instructor
- ☐ Licensed Social Worker
- ☐ Physician
- ☐ Respiratory Therapist
- ☐ Physical Therapist
- ☐ Other_________________________
- ☐ Psychologist
- ☐ Mental Health Counselor
- ☐ Psychiatrist
- ☐ Podiatrist
- ☐ Audiologist
- ☐ Optometrist

1. Indicate nature of applicant's disability (check all that apply) *Medical Professional ONLY.*

- ☐ Impaired or assisted ambulation: Specify mobility aid: _______________
- ☐ Cerebrovascular Accident
- ☐ Autism
- ☐ Deaf/Hard of Hearing
- ☐ Cardiac
- ☐ Kidney Disease
- ☐ Dialysis
- ☐ Legally Blind
- ☐ Severely Visually Impaired
- ☐ Alzheimer's
- ☐ Dementia
- ☐ Cerebral Palsy

- ☐ Pulmonary: Does applicant travel with Portable Oxygen Tank?
  ☐ Yes ☐ No
- ☐ Intellectual Disability (indicate one: ☐ Moderate ☐ Severe ☐ Profound)
- ☐ Mental Illness (Specify type) ____________________________________
- ☐ Seizures: Specify nature of: ____________________________________
- ☐ Arthritis: Specify extremity: ____________________________________
- ☐ Neurological Handicap (Specify) _________________________________
- ☐ Other____

2. In your opinion can the applicant use the:

☐ Fixed Route (city bus) OR ☐ ADA Paratransit (origin to destination)

If origin to destination service is needed, please describe the physical and/or cognitive condition and how it functionally prevents the applicant from using regular city buses:

____
____
____

3. What is the expected duration of the applicant disability?

☐ Permanent

☐ Temporary (Duration: from__________ to ________)

If the applicant has a cognitive disability, is the applicant able to:

- Give addresses and telephone numbers upon request? ☐ Yes ☐ No
- Recognize a destination or landmark? ☐ Yes ☐ No
- Deal with unexpected situations or unexpected change in routine?
  ☐ Yes ☐ No
- Ask for directions and follow directions? ☐ Yes ☐ No

4. Does the applicant require a Personal Care Attendant?

☐ No ☐ Sometimes

☐ Yes ☐ Do not know

5. If vision impaired, what is the visual acuity:

Right eye________________ Left eye_________________

Visual Field Restriction:

Right ___________________Left_____________________

Visual impairment diagnosis: ____
____
____

6. Please indicate the primary mobility aid used when traveling in the community:

☐ Cane	☐ Segway	☐ Oxygen Tank
☐ Crutches	☐ Prosthesis	☐ Manual Wheelchair
☐ Blind	☐ Power Wheelchair	☐ Leg Braces
☐ Walker	☐ Service Animal	☐ Foldable Wheelchair
☐ Scooter	☐ Hearing Device	☐ None

☐ Other _________

7. How far can applicant walk or wheel themselves without assistance from another person?____

____

8. Is the applicant able to wait outside in different weather conditions without support for 30 minutes?

☐ Yes ☐ No ☐ Sometimes

If No or Sometimes: (Explain) ____

____

____

PROFESSIONAL CERTIFICATION *Medical Professional ONLY*

Qualified professional must complete this section. Please print or type.

Person Completing Form: ______________________________

Professional Title: ___________________________________

Agency/Affiliation: ___________________________________

Business Address:____________________________________

City:_______________State: ________Phone: ______________

Please return your completed application to:

By Mail:
Brazos Transit District
ADA Paratransit Applications
1759 N. Earl Rudder Freeway
Bryan, TX 77803

By Fax:
Brazos Transit District
ADA Paratransit Applications
Fax (979)778-3606

If at any time you have any questions completing this application, please call Brazos Transit District at (979)778-4480 or (800)272-0039.

Brazos Transit District OFFICE USE ONLY

Date Application Received: ____________________

Date Approved: ____________________Date Denied: __________________

Date Applicant Notified: _______________________

Staff Signature: ____

Eligibility Dates: ____________________to __________________