Josephine Community Transit

JCT PARATRANSIT CERTIFICATION FORM

PLEASE READ THIS SECTION BEFORE YOU BEGIN

About this application — The Americans with Disabilities Act (ADA) ensures that people with disabilities receive public transportation comparable to the public transportation available to people without disabilities. JCT provides door to door service also known as dial-a-ride — to people who are unable to use the fixed route transit service for some or all of their trips because of a disability. This application form is intended to determine when and under what circumstances the applicant can use buses and when dial-a-ride service in required. This service is available for any trip purpose without restrictions.

Who should apply? Anyone with a disability which prevents them from traveling to or from a regular bus stop, or from independently boarding, riding and getting off a regular fixed route transit vehicle. If you need assistance from another person, other than the driver, when riding a fixed route your assistant can ride for free.

Instructions — the applicant (or someone assisting them) must complete PAGES 1-6. A Licensed Professional must complete and sign the PROFESSIONAL VERIFICATION section (page 7). In addition, an in-person interview with JCT staff may be scheduled to determine eligibility. Information regarding the JCT Paratransit program and its services will be explained to applicants at that time. Applicants will then be informed of JCT's determination by mail. If you have any questions about completing this application, call JCT at (541)474-5452. Hearing impaired can call 7-1-1 for assistance.

INCOMPLETE APPLICATIONS WILL BE RETURNED UNPROCESSED

When completed, return the entire form to:

Josephine Community Transit
125 River Heights way
GRANTS PASS, OR. 97527
Fax - 541-474-5414

JCT has up to 21 days after the receipt of a completed application to make a qualification determination

Josephine Community Transit

First Name ____________________________ Last Name ________________________________

Address ____

City _______________________________ State ____________________ Zip _____________

Home Phone __________________________________ Work Phone _______________________

Date of Birth _________________________________ Male ☐ Female ☐ Other ☐

Name of emergency contact person____

That person's phone number____

****

FOR OFFICE USE ONLY

Received Date ____________________ **Review Date** ______________________

Approved for Paratransit Service ☐**Yes**_____ **Approved for +62** ☐**Yes**______

Category #_______ ______________________ ________________________________

Outside ¾ mile service boundary ☐**Yes** ☐**No** **Personal Care Attendant** ☐**Yes** ☐**No**

Other ____

Reviewed by _____________________

Which of the following mobility aids (supplied by you) do you use when traveling?

A ☐ Motorized wheelchair ☐ Scooter ☐ Manual wheelchair

B. ☐ Cane ☐ Walker ☐ Crutches

C. ☐ Oxygen

D. ☐ Service Animal Type of Animal_______________________________________
What task has your service animal been trained to assist you with?
____

E. ☐ Personal Care Attendant (PCA)-someone designated by you to assist you with one or more daily life functions and as necessary with your mobility.

F. For what reason is a PCA needed?
____

____

Can you use the bus stop nearest your home? ☐ Yes ☐ No
If "no", why not? (Example: no shelter, no curb cut, no bench, etc.)

____

How far, in city blocks, is the nearest bus stop to your home? ___________________________________

Please check a box for each question:	Always	Never	Sometimes
a. I can ride JCT buses by myself (without assistance from someone Other than the driver)	☐	☐	☐
b. I need a lift to board the bus	☐	☐	☐
c. I can walk (or travel with my mobility device) to the bus stop	☐	☐	☐
d. I could probably ride the regular bus	☐	☐	☐

Please explain any box checked "Sometimes"

____

____

Have you ever ridden a regular JCT bus? ☐ Yes ☐ No

Have you ridden a regular JCT bus in the past 6 months? ☐ Yes ☐ No

If yes, how many times a month do you ride? ________________________

What bus route(s) do you usually ride? ____

What are the major factors in your decision to apply for the JCT Lift service?

____`

____

Are you able to complete the following tasks without assistance from another person? (Check a box for each question.)

	Always	Never	Sometimes
a) Get to/from a bus stop	☐	☐	☐
b) Walk, or travel using a mobility device 5 blocks	☐	☐	☐
c) Get on or off a regular bus without using the ramp/lift	☐	☐	☐
d) Get on or off a regular bus using the ramp/lift	☐	☐	☐
e) Climb 3 ten inch steps	☐	☐	☐
f) Wait at a bus stop for 30 minutes	☐	☐	☐
g) Maintain your balance entering, exiting and riding a regular bus	☐	☐	☐
h) Understand and follow verbal instructions	☐	☐	☐
i) Recognize correct stops and landmarks to complete a trip	☐	☐	☐
j) Hear stops announced on the transit bus	☐	☐	☐

	Always	Never	Sometimes
k) Read and understand informational signs	☐	☐	☐
l) Plan a trip using public transportation	☐	☐	☐
m) Communicate information about yourself	☐	☐	☐

Please explain any boxes checked "Sometimes"___________________________________

____

____

1. What is your disability?

☐ Visual Impairment____
☐ Mobility Impairment____
☐ Cognitive/Psychological____
☐ Cardiovascular/Respiratory____
☐ Other ____

2. If you have visual impairment, please check each box that describes your disability

☐ totally blind	☐ light perception
☐ severely blurred/distorted vision	☐ night blindness
☐ mildly blurred/distorted vision	☐ severe glare sensitivity
☐ central visual field loss	☐ tunnel vision
☐ half field loss	☐ loss of depth perception

☐
other________________________________

3. How does your disability prevent you from using a regular lift-equipped bus?

____

____

____

4. Is your disability (check one) ☐ permanent ☐ temporary until ______________________
   episodic (please describe) ____

5. Do you have other health problems that JCT needs to be aware of? (examples: shortness of breath, seizures, dizziness, muscle weakness, fatigue, lack of coordination, etc.)
   ____

   ____

   ____

6. In city blocks:
   a. How far can you walk? ____________
   b. If you use a wheelchair or scooter, how far can you travel in blocks? ___________

7. Is your ability to walk (or travel using a mobility device) affected by weather?
   ☐ No ☐ Yes explain____

8. Is your ability to walk (or travel using a mobility device) affected by terrain?
   ☐ No ☐ Yes explain: ____

CERTIFICATION

A. APPLICANT

I certify that the information I gave in this application is true and correct. I understand that falsification of information may result in denial of service. I understand all information will be kept confidential, and only the information required to provide the services that I request will be disclosed to those who perform those services.

Applicant Signature ____

Date ____

B. PERSON COMPLETING FORM IF OTHER THAN APPLICANT
(please check one):

☐ I certify that the information provided in this application is true and correct, based on information given me by the applicant.

☐ I certify that the information provided in this application is true and correct, based on my own knowledge of the applicant's health, disability or condition.

Exceptions of additions____

____

____

Signature ______________________ Date ______________________

Name ______________________ Phone______________________

Address ____

City ______________________ State ____________ Zip ______________

Relationship to Applicant ____

PROFESSIONAL VERIFICATION

The Americans with Disabilities Act of 1990 (ADA) is a civil rights law which bans discrimination against people with disabilities. Based on functional ability, the applicant may be found eligible for this service. The information you provide will enable us to make an appropriate determination for this applicant. All information will be kept confidential. Thank you for your assistance.

The page MUST be completed by one of the following currently licensed professionals ONLY.

- ☐ Vocational Rehabilitation Counselor
- ☐ Special Education Teacher
- ☐ Physician
- ☐ Respiratory Therapist
- ☐ Registered Nurse
- ☐ Chiropractor
- ☐ Travel Trainer
- ☐ Psychiatrist
- ☐ Physician's Assistant
- ☐ Physical Therapist
- ☐ Occupational Therapist
- ☐ Nurse Practitioner
- ☐ Social Worker
- ☐ Mobility Instructor

Patient Name ____

Diagnosis ____

____

Functional Limitations____

____

Is this condition temporary? ☐ No ☐ Yes, for weeks/months __________

I certify that the information contained in this application is true and correct to the best of my knowledge and ability.

Signature _________________________ Date ______________________________

Print Name ________________________ Daytime Phone ______________________

Clinic/Agency __________________________

Address ____