ATRANS APPLICATION
FOR
A.D.A. PARATRANSIT ELIGIBILITY CERTIFICATION

Information obtained in this certification process will only be used by ATRANS 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.

NAME: _____

HOME ADDRESS: _____

MAILING ADDRESS: _____

TELEPHONE NUMBER: _____ WORK TELEPHONE NUMBER: _____

DATE OF BIRTH: _____

WHAT IS THE DISABILITY WHICH PREVENTS YOU FROM USING THE FIXED ROUTE SERVICE?

IS THIS CONDITION TEMPORARY? Yes ☐ No ☐

IF YES, EXPECTED DURATION UNTIL: _____

HOW DOES THIS DISABILITY PREVENT YOU FROM USING FIXED ROUTE SERVICES? (**Please explain completely and attach another sheet of paper if more space is needed.**)

The following information will be used to ensure that an appropriate vehicle is utilized to provide your transportation and that an accurate analysis of your trip requests can be made by ATRANS.

DO YOU USE ANY OF THE FOLLOWING MOBILITY AIDS? ***(Check all that apply)***

POWERED SCOOTER ☐ CRUTCHES ☐ CANE ☐

MANUAL WHEELCHAIR ☐ ELECTRIC WHEELCHAIR ☐

PERSONAL CARE ATTENDANT ☐ GUIDE DOG ☐

OTHER (Please specify):

DO YOU REQUIRE A PERSONAL CARE ATTENDANT WHEN YOU TRAVEL? Yes ☐ No ☐

IF YES, NAME OF CERTIFIED PERSONAL CARE ATTENDANT:

CAN YOU TRAVEL 200 FEET WITHOUT THE ASSISTANCE OF ANOTHER PERSON? Yes ☐ No ☐

CAN YOU TRAVEL 1/4 MILE WITHOUT THE ASSISTANCE OF ANOTHER PERSON? Yes ☐ No ☐

CAN YOU TRAVEL WITHOUT THE ASSISTANCE OF ANOTHER PERSON? Yes ☐ No ☐

CAN YOU CLIMB THREE 12 INCH STEPS WITHOUT ASSISTANCE? Yes ☐ No ☐

CAN YOU WAIT OUTSIDE WITHOUT SUPPORT FOR TEN MINUTES? Yes ☐ No ☐

HEREBY CERTIFY THAT THE INFORMATION GIVEN ABOVE IS CORRECT.

SIGNATURE _____ DATE _____

IF THIS APPLICATION HAS BEEN COMPLETED BY SOMEONE OTHER THAN THE PERSON REQUESTING CERTIFICATION, THAT PERSON MUST COMPLETE THE FOLLOWING:

NAME: _____

ADDRESS: _____

DAY-TIME TELEPHONE NUMBER: _____

SIGNATURE: _____

Consent to Contact Physician or other Professional

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

One of the following listed below is familiar with my disability and is authorized to provide information to the city of Alexandria municipal transit system, ATRANS. ***(Please check one)***

Physician ☐ Health Care Professional ☐ Rehabilitation Professional ☐

Please provide the contact information for the professional you have selected above. This information is **required** to complete this certification application.

NAME:_____

(Please print)

ADDRESS: _____

TELEPHONE NUMBER: _____

Please sign and date below to authorize ATRANS to contact physician or other professional.

SIGNATURE: _____

DATE: _____