DISABLED

Date:_____

Application for Determination of Transportation Eligibility

If you believe that you have a disability that prevents you from using BJCTA/MAX or other transportation services, please complete this form.

It is important that all parts of this form are completed. All information will be kept confidential.

Please return all four pages, fully completed and with signatures to:

Travelers Aid of Greater Birmingham
1605 5th Avenue North
Birmingham, AL 35203
or
Fax :(205) 322-0108 Email: travelersaid@bellsouth.net

PLEASE PRINT CLEARLY

☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** ☐ **Miss**

_____

Last **First** **Initial**

_____

Physical Address

_____

Address

_____

City **State** **Zip**

Mailing Address (if different)

_____

Address

_____

City **State** **Zip**

Date of Birth (mm/dd/yyyy) _____/_____/_____ **Phone ( ) _____**

In Case of Emergency, Notify:

Name_____ Phone _____ Relationship _____

Disability Information:

A. Please **give detailed information of the disability or condition** that prevents you from using BJCTA/Max or other transportation services.

_____

_____

_____

_____

Is your Health Condition or Disability temporary?

☐ I don't know ☐ No ☐ Yes, How long to you expect it to last?

_____

_____

Mobility Information:

B. Which of the following mobility aids do you use? (please check all that apply)

☐ Cane ☐ Powered Scooter

☐ Crutches ☐ Electric Wheelchair

☐ Manual Wheelchair ☐ Walker

☐ X Wide Wheelchair ☐ None of these

☐ Other (please describe)_____

_____

_____

If you use a manual or powered wheelchair or scooter, what make and type is it?

_____ _____

Make Type

NOTE: Common wheelchairs and mobility aids means belonging to a class of three or four wheeled devices, usable indoors, designed for and used by persons with mobility impairments which do not exceed 30 inches in width and 48 inches in length, measured 2 inches above the ground, and do not weigh more than 600 pounds when occupied. (ADA Accessibility Guidelines for Transportation Vehicles, Subpart A-General, 1192.3)

C. Using a mobility aid or own your own, how many blocks can you travel? _____ Blocks

D. Does your disability or health condition change due to weather conditions, etc., from time to time in ways which affect your ability to use other transportation services?

Please describe: _____

_____

_____

E. Do you require an attendant to accompany you when you travel by public transportation?

☐ No ☐ Yes

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 that all information required to provide the service I am requesting will be disclosed to those who perform those services only. All information will be kept confidential by Travelers Aid of Greater Birmingham.

Signature of Person Requesting Service: _____

PROFESSIONAL VERIFICATION

NOTE: THIS PORTION TO BE COMPLETED BY ONE OF THE FOLLOWING CURRENTLY LICENSED PROFESSIONALS BUT NOT LIMITED TO:

Registered Nurse, Physician, Social Worker, Psychologist, Nurse Practitioner, Chiropractor, Occupational Therapist, Speech Pathologist, Physician's Assistant, Mental Health Counselor, Vocational Rehabilitation Counselor, other Professionals and or Agency Providers will be considered as acceptable.

The Americans with Disabilities Act (ADA) is a civil rights bill which bans discrimination against people with disabilities. To meet their needs, public companies must provide a variety of services.

The applicant may be found eligible for paratransit van services for all trips he/she requests, or eligible (based on functional ability) for some trip request but not for others, or capable of using the regular bus.

The information you provide will enable us to make an appropriate determination for each trip request. All information will be kept confidential.

Capacity for which you know the applicant: _____

☐ I have reviewed all of the information contained in this application, and I hereby certify that all information is true and correct to the best of my knowledge and ability.

Client/Patient Name: _____

Date: _____

Print Name & Title: _____
Professional

Signature: _____
Professional

Clinic/Agency: _____

Address: _____

Phone Number: _____