42 Clark Street, Warren, PA 16365
814-723-1874

For office use only:

I.D. Number_____ Evaluation Date_____ Date issued_____

REQUEST FOR CERTIFICATION OF ADA PARATRANSIT ELIGIBILITY

The Americans with Disabilities Act (ADA) requires that disabled individuals be guaranteed access to transportation services. TAWC's paratransit services are provided for disabled persons unable to use fixed route services.

HOW TO APPLY FOR TAWC PARATRANSIT ADA ELIGIBILITY:

1. Fill out PART A of this application.
2. Take or send the application to your health care professional to have PART B completed.
3. Drop or mail the completed application to TAWC, 42 Clark Street, Warren, PA 16365.
4. TAWC will notify you as to your eligibility status.

PART A – APPLICANT

1. Name of Applicant_____
2. Address_____

   City_____ State_____ Zip_____

   If address is a P.O. Box or RD #, please give street address, road number or etc.

   _____
3. Telephone Number _____
4. Date of Birth____/_____/_____
5. Male_____ Female_____
6. What is the disability that prevents you from using our fixed-route service?

   _____
7. Is this condition temporary? _____ yes _____ no

   If yes, expected duration until (date) _____/_____/_____

8. How does this disability prevent you from using our fixed-route service? Please explain completely. (Use additional sheet is necessary.)_____

_____

_____

9. Are there any other effects of your disability of which we need to be aware?

_____

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 THE WARREN COUNTY TRANSIT AUTHORITY (TAWC).

10. Do you use any of the following aids (check all that apply)?

_____ Manual Wheelchair _____ Electric Wheelchair

_____ Power Scooter _____ Cane

_____ Crutches _____ White Cane

_____ Guide Dog _____ Walker

11. Are there any other effects of your disability which we need to be aware of?

_____ Obesity/weight _____ Seizures

_____ Paralysis _____ Need of catheter

_____ Shortness of breath _____ Dizziness

Other. Please explain_____

_____

12. Do you require a Personal Care Attendant (PCA) when you use TAWC?

Yes_____ No_____

13. Please answer the following questions:

Can you travel 200 feet without the assistance of another person?

Yes_____ No_____ Sometimes_____

Can you travel ¼ mile without the assistance of another person?

Yes_____ No_____ Sometimes_____

Can you travel (insert maximum corridor dimension) without the assistance of another person? Yes_____ No_____ Sometimes_____

Can you travel three 12-inch steps without assistance?

Yes_____ No_____ Sometimes_____

Can you wait outside without support for ten minutes?

Yes_____ No_____ Sometimes_____

14. In case of an emergency, is there someone in the local area who should be notified? ____ Yes ____ No

Name_____

Address_____

Phone_____

15. I hereby certify that the information given above is correct. I authorize a health care professional to complete required information.

Signed_____ Date_____

16. If you have completed this application for another person you must provide the following information:

Your name_____

Address_____

Phone_____

Signature_____ Date_____

PART B

THE FOLLOWING IS TO BE COMPLETED BY PHYSICIAN, HEALTH CARE PROFESSIONAL OR REHABILITATION PROFESSIONAL.

In order to allow the Transit Authority to evaluate their request, it is necessary that a physician or other health care professional confirm the information provided above. The following is familiar with this person's disability and is qualified to provide this information to the Warren County Transit Authority so that they may complete this ADA certification for transportation.

Office Name_____

Name_____ Title_____

Address_____

Phone #_____

A. Indicate (X) nature of applicant's disability (check as many items as may apply)

1. ___Non-Ambulatory (uses Wheelchair for mobility)
2. ___Impaired or Assisted Ambulation requiring:

   Specify Mobility Aid
3. ___Arthritis-Specify Extremity
4. ___Amputation-Specify Extremity
5. ___Cerebrovascular Accident
6. ___Pulmonary Ills

   Does applicant use a Portable Oxygen Tank? Yes No
7. ___Neurological Handicap
8. ___Cardiac Ills
9. ___Kidney Disease-Dialysis
10. ___Sight Disabilities

    Legally Blind, Visually Impaired
11. ___Incoordination
12. ___Mental Retardation (circle level)

    Moderate Severe Profound
13. ___Cerebral Palsy
14. ___Autism
15. ___Severe Muscle Spasms
16. ___Seizures
17. ___Loss of Consciousness

18. ___Mental Illness – Please specify what it is about this cognitive disability that makes this individual unable to use regular public transit buses.

_____

_____

Describe type and severity of disability in detail and how it prevents use of transit:

_____

_____

_____

I hereby certify that I have reviewed this application and I confirm that this person listed above if unable to ride the regular fixed-route service bus due to the handicap listed above on this application. I confirm that the disability information given above is correct and, because of this disability, the person listed above is in need of transportation according to the ADA Certification laws.

Signed: _____ Date: _____