East Chicago Transit

5400 Cline Avenue
East Chicago, Indiana 46312
Business Phone 219-391-8465
Indiana Relay (711)or 800-743-3333

PARATRANSIT VAN SERVICES
APPLICATION FOR ELEGIBILITY

TO THE INDIVIDUAL COMPLETING THIS APPLICATION

The Americans with Disabilities Act (ADA) is a federal law that protects the passenger's right to accessible public transportation. ECT provides curb to curb van service for passengers who are unable to use the fixed route bus due to a disability. This form of transportation is comparable to fixed route bus service in the ECT service area. Passengers must complete ECT ADA application to be considered for the van service.

1. All questions must be answered. Incomplete and/or unsigned forms will not be accepted and may cause a delay in your eligibility determination.

2. Completed applications will be processed within 21 days of receipt. You will be notified by letter of your eligibility determination for ADA Paratransit service. If you have not been notified within 21 days, please call and we will provide you with Paratransit services until your application is processed and a final determination of eligibility is determined.

3. This is a complimentary service. A disability does not necessarily qualify you for paratransit services. Your disability must impact your ability to board, ride and get off an accessible fixed route bus.

If you have any other questions or need assistance filling this application, please contact
East Chicago Transit
219-391-8465

CERTIFICATION AND AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

My name is _____. I hereby authorize any human service agency, hospital or physician to disclose and disseminate to East Chicago Transit any confidential medical information as it relates to my injury, medical condition or disability which may include, but is not limited to, diagnosis, evaluation, treatment plan, examination results, etc. to the extent that such medical information relates to the disability and or impairment set forth in the application I filed for the East Chicago Transit Paratransit Service.

I release the human service agency, hospital, or physician from any liability which may result from this release of confidential medical information, or which may arise as a result of the use of the information contained in the information released. This consent is subject to revocation by the undersigned at any time except to the extent that action has already taken in reliance on it.

This Authorization will automatically expire one (1) year after the date of execution set forth below.

I certify that the information I have furnished to East Chicago Transit in regards to the name and addresses of the health care practitioners who have information regarding the injury, medical condition or disability is complete, accurate and truthful.

I understand that any information provided will be considered confidential and will be used only to make a determination with regard to my request for East Chicago Transit, Paratransit Services.

Applicants printed name: _____

Applicant's signature: _____

Date: _____

This form must be <u>filled out completely</u> and submitted with the application.

East Chicago Transit

APPLICATION FOR ELIGIBILITY PARATRANSIT VAN SERVICE

The Americans with Disabilities Act of 1990 (ADA) is a civil rights bill, which bans discrimination against people with disabilities. To meet their needs, public bus companies must provide a variety of services. If you have a disability which prevents you from using a ramp equipped ECT bus some or all of the time, you may be eligible for Paratransit Van Service some or all of the time.

All information will be kept confidential. Only the information required to provide the services you request will be disclosed to those who perform those services. Your answers will not be shared with any other person or company.

It is important that all parts of this form are completed. Your Health Care Provider must fill out page 13. If the application is not complete, it will be returned to you and that will delay having your application processed.

ECT reserves the right to conduct an independent evaluation of skills if the information provided is inconclusive or incomplete. The completed application is to be returned to: **East Chicago Transit**
5400 Cline Ave
East Chicago, IN 46312

If you have any questions, please call 391-8465. PLEASE PRINT

Last Name _____ First _____ Initial _____

Address _____

City _____ State _____ Zip _____

Date of Birth (month/day/year) ____ / ____ / ____ Age ____ Male Female

Work Phone _____ Home Phone _____ TDD _____
Language Ability English Spanish Other (specify) _____

Is this a request for temporary van service or permanent van service? (Circle one)

Have you applied for Paratransit eligibility previously? Yes No

Emergency Contact Name _____ Relationship _____

Work Phone _____ Home Phone _____

A. Mobility Information

1) Which of these mobility aids or equipment do you use too help you get where you need to go? Please check all that apply to you.

None_____ Cane_____ Personal Care Attendant_____
Manual wheelchair_____ Service Animal_____ Walker_____
Power wheelchair _____ Power scooter _____
White cane_____ Picture Board _____ Crutches_____
Portable Oxygen_____ Other _____

2) Using a mobility aid or on your own, how many blocks can you go on level ground?

0 Blocks 1 Block 2 to 4 blocks more than 4 blocks
How does your disability **prevent** you from traveling more blocks?

_____

_____

If you use a power wheelchair or scooter, how many blocks can you travel? Without help? Imagine a city block to be about 500 feet long.)

___0 Blocks ___1 block ___2 blocks ___3 blocks ___4 blocks
___5 blocks ___6 blocks ___7 blocks ___8 blocks ___9 blocks

How does your disability prevent you from traveling more blocks?

_____

3) If you were to ride the regular ECT bus would you need someone with you?
To help me get to or from the bus stop? ___Always ___Sometimes ___Never
To help me get on or off the bus? ___Always ___Sometimes ___Never
To help me when I get where I am going? ___Always ___Sometimes ___Never

4) Have you ever had any training to learn how to use a regular bus?
___No ___Yes

Did you complete the training? ___Yes ___No

I learned (check all that applies to you):
___General Bus Travel
___How to ride one or two specific routes

5) Do you currently use the regular bus?
___Yes ___No

B. **Disability or Health Condition Information**

Please read pages 5 and 6 before completing this section and indicate all conditions that affect your ability to use the bus.

1) General Medical Conditions

___None ___Cancer ___Diabetes
___Kidney Dialysis ___Organ Transplant ___Pneumonia
Other _____

How does this condition affect your ability to ride the regular ECT Bus?

_____

_____

2) Bone and Joint Conditions

___None ___Ankylosing Spondylitis ___Arthritis
___Fusion ___Osteo-arthritis ___Osteoporosis
___Rheumatoid Arthritis ___Scleroderma
___Amputation (please specify) _____
___Broken Bone (please specify) _____ When? _____
___Other _____

How does this condition affect your ability to ride the regular ECT Bus?

_____

_____

3) Brain/Nerves/Muscle Conditions

___None
___Cerebral Palsy ___Alzheimer's Disease ___Brain Injury
___Guillian-Barre ___Dementia ___Epilepsy
_____Multiple Sclerosis ___Vertigo/Dizziness ___Paraplegia
___Parkinson's Disease ___Post-polio ___Quadriplegia
___Spina Bifida ___Vertigo/Dizziness ___Stroke
___Muscular Dystrophy ___Huntington's Chorea ___Hemiplegia
Other _____

How does this condition affect your ability to ride the regular ECT Bus?

_____

_____

4) Heart and Circulatory Conditions

___None ___Congestive Heart Failure ___Edema
___High Blood Pressure ___Heart Surgery ___Angina
___Peripheral Vascular Disease ___Heart Attack
Other _____

How does this condition affect your ability to ride the regular ECT Bus?

_____

_____

5) Lung and Breathing Conditions

___None ___Allergies ___Asthma
___Chronic Obstructive Pulmonary Disease (COPD)
___Cystic Fibrosis ___Emphysema ___Lung Cancer
Other _____

How does this condition affect your ability to ride the regular ECT Bus?

_____

_____

6) Vision/Hearing/Speech Conditions

___None ___Aphasia ___Blind
___Hard of Hearing ___Cataracts ___Deaf
___Diabetic Retinopathy ___Glaucoma ___Night Blindness
___Partially Sighted ___Visual Field Deficit
___Registered Legally Blind
Other _____

How does this condition affect your ability to ride the regular ECT Bus?

_____

_____

7) Developmental/Mental Conditions

If developmental and/or mental retardation is checked, please attach a neuropsychological evaluation showing full scale intelligent quotient (FSIQ) or mental age, as applicable.

___None ___Autism
Developmental Disability: ___Mild ___Moderate ___Severe
Mental Retardation: ___Mild ___Moderate ___Severe
Mood Disorder ___Psychosis ___Thought Disorder
Other _____

How does this condition affect your ability to ride the regular ECT Bus?

_____

_____

8) Is your health condition or disability temporary?

___Yes How long do you expect it to last? # months _____ # years _____
___No How long have you had this condition / disability?
___I Don't Know ___Since Birth #months_____ #years_____

9) Does your disability or health condition change from time to time in ways which affect your ability to use the bus?

___No ___Yes Please Describe: _____

_____

_____

C. Functional Assessment

(To be completed by applicant)

Task Description	**Cannot Perform Task**	**Perform Task With Assistance**	**Perform Task Independently**
Climb Stairs	___	___	___
Read Information Signs	___	___	___
Hear Spoke Directions	___	___	___
Use ECT Buses	___	___	___

If you have a cognitive disability are you able to:

- Recognize a destination or landmark? ___Yes ___No
- Ask for, understand and follow directions? ___Yes ___No
- Safely and effectively travel through crowded and/ or complex facilities? ___Yes ___No
- Give addresses and telephone numbers upon request? ___Yes ___No
- Deal with unexpected situations or an unexpected change in routine? ___Yes ___No

Please use the following space to explain in detail what you can or cannot do on your own:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

D. Regular Bus Use Information

(**Please answer all questions even if you do not ride the regular ECT bus.)**

1. Do you ride the regular ECT Bus?

___Yes How many days per week? _____ How many days per month? _____

___No

___No, but I used to ride the bus How long ago did you stop? _____
Why did you stop? _____
_____

2. Can you communicate with a bus driver yourself or with the help of an aid (such as a letter board or bus route ID cards)?

___Yes ___No Please check all that apply to you.
___I cannot understand the driver
___I need a communication aid and don't have one
___Other people cannot understand me
___Other _____

3. How many blocks do you need to go to get to an ECT bus stop from your home?

___Less than 2 ___2 TO 4 ___More Than 4 ___Don't know

4. Using a mobility aid or on your own, can you make your way to the ECT bus stop by your home?

___Yes ___No Please check all that apply to you.
___I can't find the stop because I get confused

___I need someone to help me get there

___I could with training

___I don't want to ride the ECT bus

Why? _____

___The ground is too uneven or steep for me to get there

___I can't go that far

___Snow or heavy rain makes it impossible for me to get there

___Other _____

5. Can you wait 10 minutes at an ECT bus stop that does not have seats and a shelter?

___Yes

___No, but I could wait for 10 minutes at a stop, which does have seats and a shelter.

Please check all that apply to you.

___Standing for 10 minutes makes me too tired to ride the bus

___Very cold weather is dangerous to my health

How? _____

___Very hot weather is dangerous to my health

How? _____

___Other _____

6. ECT buses have ramps and kneelers to help you get on the bus if you have difficulty with steps. If you were to use the ECT bus ramp or kneeler could you get on and off the ramp by yourself (whether standing or with a mobility aid)?

___I don't know, I've never tried it

___Yes, I can get on and off by myself

___Sometimes

___No

Please check all that apply to you.

___There isn't room at my bus stop

___The ground at my bus stop is too uneven or steep

___I feel unsafe on the ramp

___My mobility aid won't fit on the ramp

___I need someone to help me on and off

___Other

7. Do you know where to get off the bus or can you find out?

___Yes ___No Please check all that apply to you.

___I get confused or can't remember where I'm going

___I don't know where the bus stop is

___I need a communication aid and don't have one

___I could with training

___Other _____

8. After you get off the bus, can you make your way to the place you need to go?

___Yes ___No Please check all that apply to you.

___I get confused or can't remember where I'm going
___I need someone to help me get there
___The ground is too uneven or steep for me to get there
___I can't walk that far
___I could with training
___Other _____

9. Are there any other conditions that limit your ability to use the bus by yourself?

___No
___Yes. Please explain. _____

E. Travel Information

Frequent Public Transit Origins and Destinations

Please list your five most frequent trips and how you get there now.

Please provide complete address of origin and destination

SAMPLE

Origin	Destination	How many times per week do you go there?
1. Home	2808 Main St.	5

How do you get there now?

___ECT Van ___ECT Bus ___Other_____

Origin	Destination address	How many times per week Do you go there?
1. _____	_____	_____
How do you get there now?		
___ECT Bus	___ECT Bus	___Other _____
2. _____	_____	_____
How do you get there now?		
___ECT Van	___ECT Bus	___Other _____
3. _____	_____	_____
How do you get there now?		
___ECT Van	___ECT Bus	Other _____
4. _____	_____	_____
How do you get there now?		
___ECT Van	___ECT Bus	Other _____
5. _____	_____	_____
How do you get there now?		
___ECT VAN	___ECT Bus	Other _____

F. Applicant Signature

1. **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 I request will be disclosed to those who perform those services. I understand that ECT may contact the health care professional who has completed the Professional Verification attached to this application. ECT may also contact your current transportation provider to complete an additional assessment of each applicant.**

Applicant Signature _____ Date _____

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2. **Person completing form if other than applicant. Please check one:**

___I certify that the information provided in this application is true and correct based upon information given to me by the applicant.

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

Exceptions or Additions: _____

Print Name _____

Signature _____ Daytime Phone _____

Relationship to Applicant _____ Date _____

Address _____

City _____ State _____ Zip _____

Once your application is received, ECT will process it within 21 days.

Section B: Professional Verification

NOTE: This portion of the application must be completed by the licensed professional who sees the applicant on a professional basis (not a friend or relative) for the disability noted within this application. This person may be a registered nurse, physician, social worker, psychologist, physical therapist, chiropractor, occupational therapist, speech pathologist, nurse practitioner, physician's assistant, mental health counselor, respiratory therapist, vocational rehabilitation counselor, or recreation therapist employed by a medical facility.

The American's with Disabilities Act of 1990 (ADA) is a civil rights law which bans discrimination against people with disabilities. To meet their needs, public transportation companies must provide van services if, and only if, the person is prevented by their condition from using the regular public bus.

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

NOTE: All ECT buses are equipped with a ramp for people who use a mobility aid or cannot climb stairs.

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

Applicant's Name _____

Professional capacity in which you know the applicant _____

Physical and/or cognitive disability which prevents the use of the regular public bus

_____

How does the disability prevent the use of a regular public bus (in detail)?

_____

_____

Is this condition temporary? ___No ___Yes, for _____ months

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

Print Name _____

Signature _____

Date _____ Daytime Phone # _____

Address _____

City _____ State _____ Zip _____

Professional License, Registration or Certification # _____

Professional License, Registration or Certification Expiration Date _____

FOR ECT OFFICE USE ONLY	**Approved:_____**	**Disapproved:_____**
	Card#: _____	**Date Issued:_____**