Office Use Only

INELIGIBLE _____ Internally Certified_____

DEMAND-RESPONSE _____

ADA PARATRANSIT
CATEGORY: 1._____2._____3._____

MAIL COMPLETED FORM TO: 1510 N Johnson St, Bay City, MI, 48708
OR FAX TO 894-2621
ANY QUESTIONS: 894-2900 ext. 1209 or 1223

BAY METRO TRANSIT
REQUEST FOR CERTIFICATION OF ADA PARATRANSIT ELIGIBILITY

1. NAME: _____

2. STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

3. TELEPHONE: (HOME): _____ (WORK): _____

(CELL): _____

4. DATE OF BIRTH: ___/___/___

5. What is the disability which prevents you from using fixed route service?

_____

_____

6. Is this condition temporary? ____ If yes, expected duration: ___/___/___

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

_____

_____

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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 request can be made by Bay Metro Transit.

8. Do you use any of the following aids to mobility? (Check all that apply)

Manual Wheelchair _____ Electric Wheelchair _____

Powered Scooter (Amigo) _____

Service Animal _____

If service animal is checked, describe type and purpose _____

_____

Personal Care Attendant _____

If PCA is checked, does the PCA travel with you all the time? Yes ___ No ___

9. Please answer the following questions:

Can you travel 200 feet (1 block) without the assistance of another person?

Yes _____ No _____

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

Yes _____ No _____

Can you travel ¾ mile 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 ___

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10. I hereby certify that the information given above is correct.

Signed _____ Date: ___/___/____

In order to allow Bay Metro Transit to evaluate your request, it may be necessary to contact you to arrange an in-person meeting. Bay Metro Transit will contact you to set up the day and time. Transportation will be provided at no cost if this meeting is necessary. Please list the best days of the week and times during the day that you are most often available.

_____

_____

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

The following physician and/or healthcare professional is familiar with my disability and is authorized to provide protected information under HIPAA to Bay Metro Transit required to complete this certification for a period of no more than 60 days from the date of my signature below.

NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

OFFICE TELEPHONE: _____

Applicant Printed Name: _____

Applicant Signature: _____Date: _____