APPLICATION FOR PARATRANSIT ELIGIBILITY

PLEASE READ BEFORE COMPLETING THE APPLICATION

If you have any questions regarding this application, please contact the Paratransit Certification/Enrollment Office at (770) 429-7855.

Dear Applicant:

The questions in PART A of this application represent the first step in the process to certify your application for eligibility to use COBBLINC's Paratransit Service. Please answer each question because the answer will assist us in determining the appropriate service to match your abilities. A DISABILITY DOES NOT AUTOMATICALLY MAKE SOMEONE ELIGIBLE FOR PARATRANSIT SERVICE**.** Eligibility for ADA Complementary Paratransit service is determined by your functional ability to ride or access the fixed route accessible bus service. It is not a medical determination; it is a functional ability analysis. A disability that makes travel more difficult, but not impossible, does not qualify you for eligibility.

It is your responsibility to return the completed and signed PART A to COBBLINC. You must sign the Authorization Page of this form authorizing your Licensed/Certified Professional to release information regarding your disability and functional ability to access and use the accessible fixed route bus service. **On the Authorization Page, please be certain to provide complete information on the Licensed/Certified Professional who can appropriately answer questions about your disability and your functional ability to travel**. It is strongly recommended that the Licensed/Certified Healthcare Professional be someone who is familiar with your functional ability. In other words, a family medical doctor may have less knowledge about a person who has:

- A mental health disability as opposed to a counselor, psychologist or psychiatrist;
- A visual impairment as opposed to a mobility specialist;
- A developmental disability as opposed to a case manager or supportive employment specialist;
- A mobility impairment as opposed to a physical therapist or occupational therapist.

When the completed PART A is received by COBBLINC, PART B of the application will be faxed to the Licensed/Certified Professional who was listed by you in PART A. Your application will be considered complete once your Licensed/Certified Professional has completed and returned PART B to COBBLINC. COBBLINC will provide a decision as to your eligibility within 21 days, once the completed application is received.

Please note: the person filling out PART A of this application cannot be the same person who will fill out PART B as the Licensed/Certified Professional.

ALL QUESTIONS ON THIS APPLICATION ARE REFERRING TO YOUR FUNCTIONAL ABILITY TO USE THE FIXED ROUTE, ACCESSIBLE BUS.

PART A APPLICANT INFORMATION (PLEASE PRINT) DATE: _____

Please check one: Initial Application _____ Re-certification Application _____

Last Name _____ First Name _____ MI _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone Number ( ) _____ Cell Phone Number ( ) _____

Date of Birth_____ Male _____ Female _____

Email Address for correspondence (OPTIONAL): _____

_____

Emergency Contact Name: _____

Emergency Contact Phone Number: ( ) _____

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Closest bus stop to your residence. (If you are not sure, please call (770) 427-4444.)

_____

Name of subdivision or apartment complex: _____

Nearest major intersecting street: _____

Nearest cross street to your residence: _____

Please fill out the requested information.

List the Medical Names of Your Disabilities or Medical Conditions	Is the Condition Permanent?	Duration of Condition	Medications taken for the Condition
	Yes ☐ No ☐		
	Yes ☐ No ☐		
	Yes ☐ No ☐		
	Yes ☐ No ☐		

1. How does the condition(s) affect your ability to ride the regular (big), fixed route, accessible bus service? Be very specific. _____

   _____

   _____

2. Do you have a **Cognitive Disability**? (Have you ever been diagnosed with Traumatic/ Non-Traumatic Brain Injury, Mental Retardation, Borderline Intelligence, Down's Syndrome, Autism, etc.?) Yes ☐ No ☐

   Please explain: _____

   _____

3. Do you experience any of the following? Please check all that apply and explain:

   _____ Panic Attacks
   _____ Hallucinations
   _____ Delusions
   _____ Short Term Memory Difficulties
   _____ Long Term Memory Difficulties
   _____ Easily Wander Off
   _____ Easily Taken Advantage of by Others
   _____ Visual Difficulties
   _____ Inappropriate Behaviors
   _____ Confusion
   _____ Easily Agitated or Angered
   _____ Experience Paranoia
   _____ Cannot Identify Pictures
   _____ Cannot Read or Write
   _____ Difficulty Understanding Written or Verbal Instructions
   _____ Anxiety
   _____ Hear Voices

   Please explain: _____

   _____

4. Do you experience **Seizures**? Yes ☐ No ☐ If yes, please check all that apply and explain:

   _____Grand Mal _____Petit Mal _____Temporal Lobe _____Epileptic Lobe

   Please explain: _____

   _____

5. When having a seizure, I: Please check all that apply:

   _____ Am Difficult to Arouse
   _____ Black Out
   _____ Fall Asleep
   _____ Need Immediate Medical Attention
   _____ Stare Blankly into Space

   Please explain: _____

   _____

6. How often do they occur? _____

7. Are you currently taking medication to control them? Yes ☐ No ☐

8. Do you have a **Visual Disability** (to include Blindness)? Yes ☐ No ☐
   Please check all that apply and explain in detail:

   _____ I wear contacts or glasses.

   _____ I can recognize my stop if announcements are made.

   _____ I am legally blind and cannot distinguish my appropriate stop, disembark, and navigate the route to my destination. I do not use a guide dog or other service animal, or any assistive device.

   _____ I use a guide dog or other service animal, but I need paratransit to get to destinations that I cannot safely travel to on the route.

   _____ I can easily hear and recognize environmental sounds that help me to determine the traffic flow patterns.

   _____ I cannot easily hear environmental sounds that help me to determine traffic flow.

   _____ I cannot always get out of the roadway before the traffic signal changes.

   _____ I require a sighted guide to assist me with the following tasks:

   _____

   _____

9. Do you have a **Mental/Psychological Disability**? Yes ☐ No ☐ If yes, please state the disability and explain how if affects you. _____

   _____

   _____

10. Are there any other physical or mental disabilities that impact your **FUNCTIONAL ABILITY** to ride the regular (big), fixed route, accessible bus service? (Example: difficulty with getting to the bus, waiting at the stop for the correct bus, boarding the bus, knowing when you get to your stop and notifying the driver that you need to get off.) Yes ☐ No ☐ If yes, please explain. _____

    _____

    _____

11. Can you wait 30 minutes at a COBBLINC bus stop that **DOES NOT** have seats and a shelter? Yes ☐ No ☐ If no, please explain. _____

    _____

12. Can you wait 30 minutes at a COBBLINC bus stop that **DOES** have seats and a shelter? Yes ☐ No ☐ If no, please explain. _____

    _____

13. Can you wait 30 minutes at a COBBLINC bus stop unassisted? Yes □ No □ If no, please explain. _____

    ___

14. How far can you walk without the assistance of another person?

    The length of one football field (300ft)? Yes ☐ No ☐

One lap around a 1/4 mile track? Yes ☐ No ☐

Two laps around a 1/4 mile track? Yes ☐ No ☐

Three laps around a 1/4 mile track? Yes ☐ No ☐

Are you able to walk up 12-14 inch steps unassisted? Yes ☐ No ☐

If unassisted, can you grip a handrail to support yourself? Yes ☐ No ☐

15. Do you require walking on a bus lift and gripping the handrail in order to board/exit the bus? Yes ☐ No ☐

16. Do you use a mobility device to travel? Yes ☐ No ☐ Please check all that apply.

_____ White Cane
_____ Orthopedic Cane (three or four prong base)
_____ Standard Cane
_____ Walker
_____ Braces
_____ Crutches
_____ Manual Wheelchair
_____ Motorized Wheelchair
_____ Scooter

17. What is the height/width of your unoccupied wheelchair/scooter?
Height _____ Width _____

18. What is the weight of your wheelchair/scooter while it is occupied by you? _____

19. Do you require the use of a service animal? Yes ☐ No ☐ If yes, what type of animal is used? _____

20. What function does the animal provide for you? _____
_____

21. Do you travel with portable medical equipment? Yes ☐ No ☐ If yes, what type of portable medical equipment? _____

22. Do you require a personal care assistant (PCA) to travel with you to provide transportation assistance? Yes ☐ No ☐ If yes, please explain the specific assistance you require. _____

23. If you do not require a personal care assistant for bus travel, are you required to be met by a caregiver when existing the bus? Yes ☐ No ☐

24. If the bus arrives at your destination and the caregiver is not there to assist you off the bus, who must be contacted? Name: _____
Telephone:_____

Please note: If the contact number is not answered, or if the number is disconnected, DFCS/911 will be called to take custody of the passenger.

25. Are there situations when your caregiver will not be required to meet the bus? Yes ☐ No ☐ If yes, please explain. _____

26. Do you need assistance recognizing your stop? Yes ☐ No ☐ If yes, please explain. _____

27. Do you use a communication device to communicate with others such as a driver? Yes ☐ No ☐ Please check all that apply.

_____ Letter Board
_____ Picture Board
_____ Route ID Card
_____ Other Form of Augmentative Communication

Please explain: _____

28. Do you require an alternate format for the Passenger Guide, Fixed Route schedules or any written correspondence? Yes ☐ No ☐ Please check the format you would like to receive them in? **Check only one format:**

_____ CD
_____ Audio tapes
_____ Braille
_____ Email
_____ Large print

29. How do you travel now? Please check all that apply.

_____ Wheelchair/scooter
_____ Walk
_____ Drive myself
_____ Passenger in someone else's car
_____ Other van service
_____ Regular (big), fixed route, accessible bus service
_____ Operate my own wheelchair
_____ Assisted in my wheelchair by a service animal
_____ Assisted in using the wheelchair by a caregiver or mobility aide
_____ Currently have no means of travel

30. Have you ever ridden a regular (big), fixed route, accessible bus? Yes ☐ No ☐ If yes, when was the last time you rode a, regular (big), fixed route accessible bus?

_____

31. Why did you stop using the regular (big), fixed route, accessible bus? _____

_____

32. Would you be able to ride the regular (big), fixed route, accessible bus system if you receive mobility training? Yes ☐ No ☐

33. Have you ever been trained in the use of COBBLINC's bus system? Yes ☐ No ☐ If yes, please explain. _____

34. Who trained you in the use of the COBBLINC bus system? _____

35. Have you ever been trained in the use of any other public bus system? Yes ☐ No ☐

36. Do you feel that you could ride the regular (big), fixed route, accessible bus if the paratransit van could get you to a regular (big), fixed route, accessible bus stop? Yes ☐ No ☐ If no, please explain how your disability restricts this. _____

_____

_____

37. Do you feel that you could ride the regular (big), fixed route, accessible bus if your trip involved riding the regular (big), fixed route, accessible bus, getting off at a bus stop and the paratransit van could pick you up at the bus stop to take you the remainder of your trip? Yes ☐ No ☐ If no, please explain why. _____

_____

_____

38. Please check all that apply to you:

_____ I am able to board, ride, and disembark from regular (big), fixed route, accessible bus.

_____ I need assistance understanding and navigating the fixed route system.

_____ I can stand on a moving bus, holding the handrail, if no seat is available.

_____ I do not have the stamina to travel long distances.

_____ I can use a telephone to get bus schedule information.

_____ I can find my way to the bus stop after being shown where it is based.

_____ I can hear and understand the automatic location announcement system on the bus.

Please explain those items checked above. _____

_____

_____

_____

To the best of my knowledge, the information I have provided as part of this application has been properly recorded. I have reviewed all answers and certify that the information is complete and correct. I understand that any intentional false or misleading information may be grounds for denial of service.

_____

Signature of applicant, representative, or guardian:

Date: _____

PLEASE COMPLETE AND RETURN THE APPLICATION TO:

COBBLINC
PARATRANSIT DIVISION
431 COMMERCE PARK DRIVE
MARIETTA, GA 30060

PATIENT CONSENT TO RELEASE & DISCLOSURE OF MEDICAL INFORMATION

This Consent to Release Medical Information is to be provided to:

*(PLEASE GIVE **COMPLETE INFORMATION ABOUT THE HEALTH CARE PROFESSIONAL***

WHO WILL VERIFY YOUR APPLICATION INFORMATION)

LICENSED/CERTIFIED PROFESSIONAL'S NAME (see list below):

_____

ADDRESS: _____

CITY :_____ STATE: _____ ZIP:_____

PHONE #: (___)_____ FAX #: (___)_____

I, the undersigned, do hereby consent to the release and disclosure of any relevant medical information to COBBLINC Paratransit Services as called for in Part B of this application for the sole purpose of determining ADA paratransit eligibility. I understand that this information will be shared only with persons making decisions related to my eligibility for paratransit services and to other transit providers needing such information to facilitate travel.

I have read this document carefully and understand that I have the right to revoke this release in writing, excepting information that may have previously been released under this authorization.

_____ _____

Signature of applicant, representative, or guardian Date

_____ _____

Witness Date

Please Note:

Below is a list of the Licensed/Certified Professionals that are authorized to complete Part B.

Physicians, registered nurse, social worker, psychologist, physical therapist, chiropractor, occupational therapist, speech pathologist, special education teacher, nurse practitioner, physician's assistant, mental health counselor, orientation/mobility specialist, respiratory therapist, vocational rehabilitation counselor, or recreation therapist employed by a medical facility.

If someone other than the applicant has completed this application/authorization, that person must complete the following:

Name _____

Relationship _____

Address_____

Home phone _____

Work phone _____

TDD/TTY_____

I certify, to the best of my knowledge that the information provided in this application is complete and correct based upon the information given me by the applicant or my own knowledge of the applicant's health condition or disability.

Signature _____ Date_____

FOR COBBLINC OFFICE USE ONLY:

APPROVED_____ CONDITIONAL_____ UNCONDITIONAL _____
CODE(S) _____

DENIED_____
LIST SPECIFIC REASON FOR DENIAL THAT WILL BE STATED ON THE DENIAL LETTER_____
_____
_____
_____

SIGNED_____DATED_____

Cobb County...Expect the Best!