Cedar Rapids Transit
ADA Paratransit Application

Attached is an application for you to complete in order to receive ADA paratransit service. If you have a disability that prevents you from using the fixed-route city bus service, you may be eligible for ADA paratransit service administered by Cedar Rapids Transit and operated under contract by Linn County LIFTS. If you are currently a Linn County LIFTS client, it will still be necessary for you to complete an application to be certified.

Public transit systems are required by the Americans with Disabilities Act (ADA) to establish a process for determining ADA paratransit eligibility. The goal of the process is to ensure that only persons who meet the ADA criteria are regarded as eligible. Eligibility is strictly limited to any person with a disability that is unable to use the regular fixed-route city bus system. Diagnosis of a disability does not establish eligibility. What is needed is a determination of whether the person can use the fixed-route city bus system under given circumstances. The person's physical and mental abilities in relation to getting on and off a bus, riding the bus, and traveling to or from a bus stop will be considered when determining eligibility for paratransit services. A person's age, income, inability to drive, travel preference or inconvenience are not considered qualifying factors. In addition, the service is only provided within the city limits of Cedar Rapids, Marion and Hiawatha.

There are three types of ADA paratransit eligibility:

- Full – if your disability prevents you from using the fixed-route city bus system for any trips.
- Conditional – if you can use the fixed-route city bus system under certain circumstances, but need the ADA paratransit service for specified trips.
- Temporary – if your disability does not require a permanent need for ADA paratransit service.

To enable us to determine your eligibility, it is your responsibility to complete Part 1 and have your physician or health care professional complete Part 2 of this application. Please be as specific as possible. The questions are meant to determine the functional abilities you have and under what circumstances you might be able to utilize the wheelchair-accessible fixed-route city bus system. If you don't believe there is enough space to answer your questions, feel free to attach a sheet to the back of this application. Please number your answers to match the question so we know what response belongs to which question. Both sections must be filled out and the entire application submitted to Cedar Rapids Transit to be considered a complete application. An incomplete application will be returned to you and will delay your eligibility determination.

Completed applications will be processed within 21-days of receipt and you will receive written notification of the decision. If you have not received a response within 22-days after mailing your completed application you shall have presumed eligibility, and may begin scheduling rides until you receive a written denial of certification. If you have any questions regarding this process or need assistance in completing your application, please call (319) 286-5537 or email m.williams@cedar-rapids.org.

Please mail your completed application to the following address:

Cedar Rapids Transit
Attn: ADA Paratransit Service Application
427 8th St NW
Cedar Rapids, Iowa 52405

Part 1 – Applicant Information

All questions must be answered by the applicant (only one applicant per form). Incomplete or illegible forms will be returned. Please circle appropriate answers below and give explanations where indicated.

Applicant Name: _____ Birthdate: _____

Address: _____

Address is a: Residence Group Home Assisted Living Apartment Care/Nursing Facility

Telephone: _____ Alternate Phone: _____

1. Please describe your current disability: (Be specific and list all applicable disabilities)
   _____
   _____
   _____

2. How does this disability prevent you from using the fixed-route city bus system? Please keep in mind that all fixed-route city buses are wheelchair accessible.
   _____
   _____
   _____

3. Is your disability: Permanent Temporary
   If temporary, what is the expected duration? _____

4. If your disability changes from day to day, please explain how:
   _____
   _____
   _____

5. Does your disability prevent you from getting to or from a fixed-route bus stop? Yes No
   If yes, please explain: _____
   _____

6. How many blocks can you travel or walk? _____ Blocks

7. Do changes in weather prevent you from getting to or from a bus stop? Yes No
   If yes, list specific weather conditions and its impact on your mobility: _____
   _____

8. Is there a physical barrier that, when combined with your disability, might prevent travel to or from the bus stop? If yes, please list: (Examples: no sidewalks, no crosswalks/lights, no curb cuts, steps) _____
   _____

9. Are you prevented from traveling to or from a bus stop for any of the following reasons? (Please circle all that apply):
   - Inability to negotiate hilly terrain
   - Allergic/environmental sensitivities
   - Night blindness
   - Hyper-fatigue or frailty
   - Extreme sensitivity to weather conditions
   - Inability to cross busy intersections
   - Other (please explain): _____

10. Can you wait ten minutes alone at a bus stop? Yes No
    (If no, please explain) _____
11. Can you climb three steps to get into a bus? Yes No

12. Can you board a bus with a “kneeling” feature which lowers the height of the first step? Yes No

13. Can you follow written instructions? Yes No Oral instructions? Yes No

14. Can you use the telephone or TTD to make calls? Yes No

15. Are you able to identify the bus you need? Yes No

16. Are you able to detect curbs, curb cuts, sidewalks, etc? Yes No

17. Do you have a visual impairment that prevents you from riding the bus? Yes No

18. Do you use a mobility aid? Yes No
    (If yes, please circle all of the following mobility aids you might use):

Manual wheelchair	Electric wheelchair	Power scooter
Walker	Support cane	White cane
Oxygen tank	Crutches	Guide/assistance animal
Ambulatory, but must use lift to board vehicle		Other _____

19. If you use a wheelchair or scooter, what are its physical dimensions two inches above the floor, including foot or head extensions (in inches)? Note: a common wheelchair does not exceed 30 inches in width or 48 inches in length when measured two inches above the ground, and does not weigh more than 600 pounds occupied.

    Width _____ Height _____ Length _____ Occupied Weight _____

20. Do you require a Personal Care Attendant (PCA) when you travel? Note: A PCA is someone who is designated or employed by a person to provide personal assistance; it is not a companion.

    Yes No Sometimes

21. Do you currently ride the fixed-route city bus system? Yes No
    If yes, how often _____ / week.

22. Have you ever received travel training on the fixed-route city bus system? Yes No
23. Would you be interested in travel training? Yes No
24. Would you like to receive information about the fixed-route city bus system? Yes No

Please provide a contact name and number of a relative or friend in case we are unable to reach you:

Name: _____ Relationship: _____

Telephone: _____ Alternate Phone: _____

I hereby certify, to the best of my knowledge, that the information I have provided in this application is correct and true. I agree to notify Cedar Rapids Transit of any changes in my status, which may affect my eligibility to use this service. In addition, I hereby authorize my health care professional to provide any additional information to Cedar Rapids Transit personnel as needed or requested to make their eligibility determination.

Signature of applicant: _____ **Date:** _____

If you have completed this application on the applicant’s behalf, you must provide the following information.

Name: _____

Address: _____

Daytime telephone: _____ Relationship to applicant: _____

Part 2 - Request for Professional Verification

(To be completed by a licensed Physician or Health Care Professional)

You are being asked by the applicant named in Part 1 to provide information regarding their disability and its impact on their ability to use the fixed-route city bus system operated by Cedar Rapids Transit. The Americans with Disabilities Act (ADA) requires public transit systems to provide paratransit service to persons who, due to a disability, are unable to use the fixed-route city bus system. The goal of the ADA paratransit eligibility process is to ensure that only persons who meet the ADA criteria are regarded as eligible.

Diagnosis of a disability does not establish eligibility. What is needed is a determination of whether the person can use the fixed-route city bus system under given circumstances. Please keep in mind that all of our fixed-route city buses are equipped with wheelchair lifts/ramps. The person's physical and mental abilities in relation to getting on and off a bus, riding the bus, and traveling to or from a bus stop will be considered when determining eligibility for paratransit services. A person's age, income, inability to drive, travel preference or inconvenience are not considered qualifying factors. The information that you provide will allow Cedar Rapids Transit to make an appropriate eligibility determination for this applicant. Thank you for your cooperation and assistance.

Applicant's Name _____

Capacity in which you know the applicant: _____

Please identify the applicant's disability and describe the impacts or limitations to mobility:

_____

_____

_____

_____

_____

Is this condition temporary? Yes No If yes, expected duration _____

If the applicant has a visual impairment, please identify the extent of impairment and describe how it prevents their use of the fixed-route city bus system: _____

_____

If the applicant has a cognitive disability, please identify the extent of impairment and describe how it prevents their use of the fixed-route city bus system: _____

_____

In your professional opinion, is this person able to ride the fixed-route city bus system? Yes No

I hereby certify that the above information is correct and true.

Physician's Signature (or stamp) _____ Date _____

Physician's Name _____ Telephone _____

Name of Practice _____ Email _____

Address of Practice _____

City _____ State _____ Zip Code _____

Medical License # _____ State _____