PLEASE READ BEFORE COMPLETING THE APPLICATION

If you have any questions regarding this application, please contact the Paratransit Certification/Enrollment Office

YOU MUST CALL OUR MAIN NUMBER AT 770-949-7665 FOR AN ADDRESS SERVICE AREA ELIGIBILITY CHECK

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 Connect Douglas Paratransit Service. Please answer each question to 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 Connect Douglas** 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 including correct fax number of 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 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.

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

PLEASE COMPLETE AND RETURN TO:

CONNECT DOUGLAS
PARATRANSIT DIVISION
8800 DORRIS RD
DOUGLASVILLE, GA 30134

Or complete the form digitally and email to: charmadavis@douglascountyga.gov

GENERAL INFORMATION (Please Print)

Please circle one: New Application ☐ Re-Certification Application ☐

Last Name: _____ First Name: _____ M. I. : _____
Residential Address: _____ Apt/Lot# _____
City: _____ State: _____ Zip: _____ County: _____
Is the provided address your mailing address? ☐ Yes ☐ No Email: _____
If not, please provide mailing address: _____
Daytime Phone #: _____ Alternate Phone #: _____
Date of Birth: _____ Gender: ☐ Male ☐ Female
Emergency Contact: _____ Relationship: _____ Phone #: _____
Indicate the following residence type in which you live:

☐ Single Family Home ☐ Apartment/ Townhouse ☐ Retirement Facility ☐ Assisted Living Facility ☐ Skilled Nursing Facility

Name of facility, if applicable: _____
When you travel outside your home, please check which (if any) of the following mobility aids you use.

☐ Power Wheelchair ☐ Cane ☐ Stretcher
☐ Manual Wheelchair ☐ Crutches ☐ Service Animal
☐ Power Scooter ☐ White Cane ☐ Personal Care Attendant
☐ Walker ☐ Respirator ☐ Other _____

If you use a manual wheelchair, can you transfer to a passenger seat for travel? ☐ Yes ☐ No ☐ N/A
Are you a disabled veteran? ☐ Yes ☐ No (If yes, please attach a copy of VA letter of disability)

SECTION A – The Americans with Disabilities Act

A1. Can you use the Connect Douglas fixed route ☐ ? ☐ YES ☐ No

A2. Please describe the condition, disability, or limitation that prevents you from riding the fixed route bus. _____

_____

_____

A3. Is this condition/disability/limitation: ☐ Permanent ☐ Temporary

If temporary, how long do you expect it to last? _____

A4. With your mobility aids, if applicable, how far can you travel?

- ☐ I can only get to the curb in front of my residence
- ☐ I can travel up to two or three blocks
- ☐ I can travel up to six blocks
- ☐ I can travel more than six blocks
- ☐ Not Applicable

A5. What is the longest time you can wait outside under the following conditions?

With a place to sit?

☐ 5 minutes or less ☐ 15 minutes ☐ 30 minutes ☐ More than 30 minutes

Without a place to sit?

☐ 5 minutes or less ☐ 15 minutes ☐ 30 minutes ☐ More than 30 minutes

A6. Can you step up and down off curbs when you travel between city blocks and/or cross streets?

☐ Yes ☐ No

A7. If you cannot use steps to board a bus, can you board a bus using any of the following? (Please note that persons who cannot climb the bus steps have the right to enter the bus by standing on the lift.) A wheelchair lift? ☐ Yes ☐ No

A ramp (incline)? ☐ Yes ☐ No

If neither, please explain_____

A8. Are you able to give your address and phone number upon request? ☐ Yes ☐ No

A9. Are you able to ask for, understand, and follow directions? ☐ Yes ☐ No If No, please explain:

_____

_____

A10. Are you able to travel safely and effectively through crowded and/or complex facilities? ☐ Yes ☐ No

A11. How do you currently travel to your frequent destinations?

- ☐ Connect Douglas fixed route bus
- ☐ Uber / Lyft
- ☐ Walk
- ☐ Family
- ☐ I drive myself
- Other_____

A12. Do you travel with the help of another person? ☐ Always ☐ Sometimes ☐ Never

A13. Are you able to get to and from the public transit stop nearest your home? ☐ Yes ☐ No

If No, please explain: _____

_____

A14. If you have a service animal, indicate the task(s) your service animal performs for you:

- ☐ Guides me
- ☐ Alerts
- ☐ I do not currently use a service animal
- ☐ Picks up items
- ☐ Pulls me
- ☐ Carries items for me (explain) _____
- ☐ Other: _____

PATIENT CONSENT FOR RELEASE & DISCLOSURE OF MEDICAL INFORMATION

(Please give **COMPLETE INFORMATION ABOUT THE LICENSED/CERTIFIED PROFESSIONAL** authorized to complete Part B of your application. The following Licensed/Certified Professionals are authorized to complete Part B: Physician, 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).

This Consent to Release Medical Information is to be provided to: **Connect Douglas Paratransit**

Name & Title of Licensed/Certified Professional:

NAME/TITLE:_____

ADDRESS: _____

CITY:_____ STATE: _____ ZIP:_____

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

I, the undersigned, do hereby consent to the release and disclosure of any relevant medical information to Connect Douglas 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

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 to me by the applicant or my own knowledge of the applicant's health condition or disability.

Signature _____ Date_____

FOR CONNECT DOUGLAS OFFICE USE ONLY:

APPROVED_____ CONDITIONAL_____ UNCONDITIONAL _____

CODE(S) _____

DENIED_____

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

_____

_____

_____

_____

SIGNED_____DATED_____

If you have any questions regarding this application, please contact the Paratransit Certification/Enrollment Office at (770) 920-7514.

ACKNOWLEDGEMENT OF ADA PARATRANSIT CERTIFICATION

The person named on the attached application has applied for CONNECT DOUGLAS Paratransit Service. CONNECT DOUGLAS provides two levels of transportation service to the public, both fixed route and paratransit.

THE ENTIRE FLEET OF CONNECT DOUGLAS BUSES ARE ACCESSIBLE AND ADA COMPLIANT.

Fixed Route

Accessible fixed route service is available to all citizens. All buses are equipped with:

- Lifts (for wheelchairs and those who cannot climb stairs),
- internal and external audio enunciators (operators make additional announcements as requested)
- Internal and external signs displaying route information.

Accessible, covered, transfer centers provide shelter and seating. Schedules and other information are available in a variety of formats to ensure accessibility.

Paratransit

Paratransit service is an origin to destination, lift accessible, and shared-ride public transportation service. The ADA statute clearly emphasizes nondiscriminatory access to fixed route service, with ADA Complementary Paratransit acting as a "safety net" for people who do not have the functional ability to use the fixed route system. Under ADA guidelines, Complementary Paratransit service is **not** intended to be a comprehensive system of transportation for individuals with disabilities, and **simply having a disability or multiple disabilities does not, in and of itself, entitle a person to ride.** Rather, the DOT ADA regulations provide for three categories of ADA Complementary Paratransit Eligibility:

- persons with disabilities who cannot use fixed route without the assistance of another person,
- persons who could use the fixed route if the vehicles were accessible, and
- any individual with a disability who has a specific impairment-related condition, which prevents such individual from traveling to a boarding location or from a disembarking location on such system.

The determining factor in deciding whether a person qualifies for *ADA Complementary Paratransit* Service is whether he/she can functionally ride or access the bus. It is not a medical determination; it is a functional ability analysis.

To expedite the processing of this application, CONNECT DOUGLAS requests that you please fill out and fax both Part A and B to **(770) 920-7515**. You may also send by email charmadavis@douglascountyga.gov

This portion MUST be completed by one of the following currently Licensed/Certified Professionals:

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.

CONNECT DOUGLAS PARATRANSIT APPLICATION PART B: TO BE FILLED OUT BY A LICENSED/CERTIFIED PROFESSIONAL

General Information

Name of Applicant:_____ Date of Birth _____

Date of applicant's last assessment or interaction with you _____

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 ☐		
	Yes ☐ No ☐		

1. Please discuss the impact this disability has on the applicant's **functional ability** to ride a CONNECT DOUGLAS assessable fixed route bus. _____

_____

_____

2. If this is a temporary disability, when will the applicant be able to resume normal travel patterns? Please list an actual date _____

_____

3. Under what circumstance does the disability worsen? _____

_____

4. Does the applicant have the mental capacity, visual and/or hearing ability to:

   Give addresses and phone numbers? _____

   Recognize a destination or landmark? _____

   Deal with unexpected change in routine? _____

   Ask for, understand and follow directions? _____

Safely/effectively travel through crowded/complex facilities? _____

5. Does the applicant require a Personal Care Attendant? ☐ Yes or ☐ No
6. Are there any other medical conditions of which CONNECT DOUGLAS should be aware?
   Yes ☐ No☐ If yes, please explain_____

_____

This certification information completed by:

Print name of certifying professional _____

Title _____

Address _____

City _____State _____Zip _____

Office Phone Number ( ) _____Fax ( )_____

E-mail Address _____

License/Certification # and State_____

What organization issued your License? _____

Signature_____Date signed _____

PLEASE RETURN BY FAX TO (770) 920-7515.

Or complete the form digitally and email to: charmadavis@douglascountyga.gov