AdVANtage Request for Certification of ADA Paratransit Eligibility

The Information obtained in this certification process will only be used by the OVRTA/EORTA for the provision of transportation services. Information regarding only your functional ability (not your medical information) may be shared with other transit providers to facilitate travel in those areas. The information will not be provided to any other person or agency.

1. Name_____
2. Address_____

   _____

   _____
3. Telephone Number (Home)_____ (Cell)_____
4. Date of Birth _____/_____/_____
5. If someone else will be telephoning to request van service for you, please supply the following information.

   Name_____

   Telephone Number (Home) _____

   (Cell)_____
6. What is the disability which prevents you from using our fixed route service?

   _____

   _____

   _____

   Is this condition temporary? _____ If yes, expected duration until ____/____/____
7. How does this disability prevent you from using fixed route services? Please explain completely. Use an additional sheet if needed._____

   _____

   _____

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

   If yes, please explain _____

   _____

   _____

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 requests can be made by OVRTA/EORTA.

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

   Manual Wheelchair _____ Electric Wheelchair ____ Guide dog ____ Powered Scooter ____

   Cane ____ Crutches ____ Personal Care Attendant (PCA) ____

10. Do you require a Personal Care Attendant (PCA) when you travel using transit? _____

    If yes, please provide the name of the PCA : _____

11. Please answer the following questions:

    Can you travel 200 feet without the assistance of another person?

    Yes _____ No _____ Sometimes _____

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

    Yes _____ No _____ Sometimes _____

    Can you climb three 12-inch steps without the assistance of another person?

    Yes _____ No _____ Sometimes _____

    Can you wait outside without support for ten minutes?

    Yes _____ No _____ Sometimes _____

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

    Signature _____ Date _____

13. If this application has been completed by someone other than the person requesting certification, that person must complete the following:

    Name _____

    Address _____

    _____

    _____

    Daytime Phone _____

    Signature _____ Date _____

Professional Verification Authorization

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

The following: (check one)

Physician _____

Health Care Professional _____

Rehabilitation Professional _____

Is familiar with my disability and is authorized to provide information to the OVRTA/EORTA as required to complete this certification.

Name of Physician/Professional _____

Address _____

_____

_____

Phone Number _____

Print Your Name _____ Date of Birth ___/___/___

Sign Your Name _____ Date ___/___/___