CITY OF MARION TRANSPORTATION SYSTEM (MTS) ADA PARATRANSIT SERVICE [ADA = AMERICANS WITH DISABILITIES ACT]

If you have a disability which prevents you from using the regular bus service provided by MTS some or all of the time, you may be eligible for MTS' new ADA Paratransit Service. This service operates the same hours as MTS' regular bus service. (Presently 7AM – 5 PM, Monday through Fridays, except certain holidays.)

In order to determine whether you are eligible for MTS' ADA paratransit service, complete the enclosed ADA Paratransit Service Application form in its entirety and mail it to the following address:

City of Marion Transportation Department
520 E. 6th Street
Marion In 46953

Attention: ADA Review Committee

Ensure that Part E of the application form (Professional Verification) is completed and signed by one of the professionals listed in Part E; applications which are not verified by a listed professional will not be considered for ADA paratransit service.

MTS will process your completed application within 21 days after it is received in the MTS' office.

If you have any questions, please call the Marion Transportation System at 668-4405, or call 668-4446 is using TDD for the hearing impaired.

City of Marion Transit System

REQUEST FOR CERTIFICATION OF AMERICANS WITH DISABILITIES ACT (ADA) PARATRANSIT ELIGIBILITY

The information obtained in this certification process will only be used by the City of Marion for the provision of transportation services. Information regarding the evaluation of your functional ability to use transit services will only 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____

   ____

   State______________ Zip____________

3. Telephone Number (Home)______________ (Work)______________

4. Date of Birth_____/_____/_____

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

   ____

   ____

   Is this condition temporary?________ If Yes, expected duration until

   _____/_____/_____

6. How does this disability prevent you from using fixed route services? Please explain completely. Use an additional sheet if needed. ______________________________

   ____

   ____

   ____

   ____

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

   ____

   ____

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 THE CITY OF MARION.

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

Manual wheelchair______ Electric wheelchair______ Powered scooter______

Cane______ Crutches______ Personal care attendant______ Guide dog______

Other service animal (Describe)________________________________

If you use a wheelchair or scooter, what is its:
Length ________ inches Width ______inches

Does the total weight of your wheelchair/scooter and yourself exceed 600 pounds? Yes______
No______

9. Do you currently use any transit or paratransit service in the region?
Yes______ No______ (Please describe the services you use) ________________________

____

10. Please answer the following questions:

What is the maximum distance you can travel without the assistance of another person? ______ yards
(For reference: 1/4 mile = 440 yards; 1/2 mile = 880 yards; 3/4 mile = 1320 yards).

Does your disability prevent you from travelling this distance in snow, ice, or over certain terrain? (Explain)

____

____

Can you climb up and down three 12 inch steps to get on and off of a bus?
Yes______ No______ Sometimes______

What is the maximum period you can wait outside without support?
______ minutes

Is this time period affected by extremes of hot or cold weather? Yes______ No______ (If Yes, please describe your situation below) ________________________

____

____

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

Signed________________________________ Date____/_____/_____

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

Name____

Address____

_______________________________ State__________ Zip____________

Daytime Phone____________________

Signed__________________________ Date____/____/____

In order to allow the City of Marion 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.

Please identify the professional best able to verify your functional ability to use transit services. For example, if you use a mobility aid or are physically unable to get to or from a bus stop or on a bus, identify, if possible, a rehabilitation counselor, independent living counselor, occupational therapist, or other such professional knowledgeable of your functional abilities. If you have a cardiac condition, pulmonary condition, visual impairment, or temperature sensitivity, identify a physician or health care professional with the appropriate specialty to provide information about your condition. If you have a cognitive or developmental disability, identify, if possible, an independent living counselor or other social service professional familiar with your capabilities.

The following Rehabilitation Counselor _____; Independent Living Counselor _____; Occupational Therapist _____; Social Service Professional _____; Physician _____; Health Care Professional _____ (check one) is familiar with my disability and is authorized to provide information to the City of Marion required to complete this certification.

Name____

Address____

____

State________________ Zip________________

Phone Number____

Print Name__________________________ Date of Birth____/____/____

Signed__________________________ Date____/____/____

Dear

The attached authorization form has been submitted by ____________________
____________________, who has indicated that you can provide information regarding his/her disability and its impact upon his/her ability to utilize our transit services. Federal law requires that City of Marion provide paratransit services to persons who cannot utilize available fixed route services. The information you provide will allow us to make an appropriate evaluation of this request and its application to specific trip requests. Thank you for your cooperation in this matter.

This section to be completed by health care professional only!

Capacity in which you know the applicant:

Medical Diagnosis of condition causing disability:

Is the condition temporary? No_____

Yes_____ Expected duration until _____/_____/_____

If the person has a disability affecting mobility:

How far can the individual travel without the assistance of another person? _____ yards. (For reference: 1/4 mile = 440 yards; 1/2 mile = 880 yards; 3/4 mile = 1320 yards).

Does the person's disability prevent them from travelling this distance when there is:
Ice_____ Snow_____ Steep Terrain_____

Is the individual able to climb up and down three 12 inch steps without assistance?
Yes_____ No_____ Sometimes _____

How long can the individual wait outside without support? _____ minutes.

Does this person have an intolerance to extremes of heat and/or cold which create a danger if the person must wait outside?
Yes_____ No_____ (If Yes, please describe nature of thermal intolerance and the cause of this disability) ____________________
____
____

Does the person use any mobility aids? If so, what? ____________________
____
____

If the person has a visual impairment:

Visual Acuity with Best Correction:

Right Eye_____ Left Eye_____ Both Eyes_____

Visual Fields:

Right Eye_____ Left Eye_____ Both Eyes_____

This section to be completed by health care professional only!

If the person has a cognitive disability:

Is the person able to:

Give addresses and telephone numbers upon request?
Yes_____ No_____

Recognize a destination or landmark?
Yes_____ No_____

Deal with unexpected situations or unexpected change in routine?
Yes_____ No_____

Ask for, understand and follow directions?

Yes_____ No_____

Safely and effectively travel through crowded and/or complex facilities?
Yes_____ No_____

Is there any other effect of the disability of which the City of Marion should be aware? Please describe.

Your Name: ____________________

Office Address: ____________________

Office Phone Number: ____________________

Signature: ____________________