

***Asotin County PTBA***  
***Public Transportation Benefit Area***

In accordance with the Americans with Disabilities Act of 1990 (ADA), Asotin County PTBA (PTBA) provides complimentary paratransit service, also know as “dial-a-ride”, to individuals with disabilities who are unable to use the available stops on our fixed route service.

The purpose of this application is to provide an opportunity for you to describe barriers in the environment and limitations that you may have which prevent you from using the available stops on the route. The information that you provide will help PTBA to understand your abilities and travel challenges. **All information contained in this application will be kept confidential and shared only with the professionals involved in evaluating your eligibility.**

**All** applicants must complete the application and provide **written** professional verification of disability. The ADA certification process helps us determine your abilities to use fixed route service.

**All questions must be answered.** Incomplete forms will be returned and cause time delays in processing your application. If you have questions or need assistance completing this form, please call (509) 758-3567.

**When completed, applications may be mailed to or dropped off at:**

**Asotin County PTBA  
1494 Poplar Street  
Clarkston, WA 99403**

**or faxed to:           (509) 758-3594**

**If you have not heard from us within 21 days, please contact Asotin County PTBA at (509) 758-3567.**

# REQUIRED INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial \_\_\_\_\_

Home Address: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_

Daytime Phone: (\_\_\_\_) \_\_\_\_\_ TTY:  Yes  No

Evening Phone: (\_\_\_\_) \_\_\_\_\_ TTY:  Yes  No

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  Female

Do you need future written information provided to you in an accessible format?

Yes  No If yes, please indicate your preferred format:

Computer Disc  Large Print

Emergency Contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Daytime Phone: (\_\_\_\_) \_\_\_\_\_ Evening Phone: (\_\_\_\_) \_\_\_\_\_

Did anyone assist you with completing this application:  Yes  No

If yes, please provide the following information about the person:

Name: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

Are you ADA certified through another agency? Yes No

1. What type(s) of disabilities prevent you from using the fixed route service? Please check all that apply.

- Physical Disability
- Visual Impairment/Blindness
- Developmental Disability
- Brain Injury
- Mental Illness
- Other \_\_\_\_\_

2. Please describe the mobility aid(s) or equipment you use when traveling outside your home.

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Your height \_\_\_\_\_ ft \_\_\_\_\_ in                      Your weight \_\_\_\_\_

3. If you are ambulatory, will you require use of the lift? Yes No

4. If you use a wheelchair or scooter, is it: N/A

30 inches wide or less? Yes No

48 inches long or less? Yes No

5. What PTBA service(s) do you currently use? Please check all that apply.

- Fixed Route
- Dial-a-Ride
- Neither

6. Do you, or will you, need the assistance of another person (PCA) to travel when using Dial-a-Ride?

- Yes
- No
- Sometimes

7. PTBA offers **FREE** travel training that will help you become familiar with the routes. Would you be interested in this training?

- Yes
- No

Your answers to questions in this section will help us better understand your functional ability in specific areas. Your answers should be based on your physical and mental ability to perform the tasks. Assume that you are using the mobility equipment that you usually use when traveling outside your home.

**1. Without assistance and using your current mobility aid, can you cross the street:**

- At quiet street with very little traffic: Yes No
- At most traffic lights: Yes No
- Anywhere: Yes No
- Never: Yes No

**2. Use the telephone to get information?**

- Yes No

**3. Without assistance and using your current mobility aid, how many blocks can you travel?**

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**4. If you answered none to Question 3, please explain the barriers that prevent you from traveling:**

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**5. Can you cross the street, if there are curb cuts?**

- Yes No

**6. Step on and off a curb from a sidewalk?**

- Yes No

**7. Find your own way to or from a transit stop after being shown?**

- Yes No

**8. Are you able to get on or off a bus using the lift?**

Yes       No

**9. Are you able to grasp hand rails while boarding and exiting the bus?**

Yes       No

**10. Are you able to maintain your balance when seated on the bus?**

Yes       No

**11. If the weather is good and there are no environmental barriers, how far can you travel outside independently, using your mobility device if applicable?**

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**Please tell us anything else you would like us to know that affects your ability to board, exit or ride the fixed route.**

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Asotin County PTBA's ADA eligibility process includes:

1. Receipt of your **completed** application, including professional verification (pages 8-9 of this packet). (*Incomplete applications will be sent back to you and cause delays in processing*).
2. Once we have received your **completed** application, PTBA will process it within 21 days and notify you of your eligibility.
3. If you have not heard from our office after 21 days, you will be granted **Presumptive Eligibility**. This will allow you to use dial-a-ride service until a final determination has been made.
4. Your eligibility notification will be sent to you in the form of a letter. If you disagree with the decision, you have **65 days** from the date on your determination letter to file the Request to Appeal form. After we receive your form:
  - Asotin County PTBA will review the additional information and make a final determination within thirty (30) days;

or

  - You may request to present your additional information in person to the ADA Eligibility Appeals Committee, who will make a determination within thirty (30) days. You may have someone accompany you.

**Applications and/or appeals may be mailed, faxed, or delivered to:**

Asotin County PTBA  
ATTN: ADA Compliance  
1494 Poplar  
Clarkston, WA 99403  
Fax: (509) 758-3594

**I certify that the information in this application is true and correct. I understand that falsification of the information may result in denial of some ADA eligibility services.**

**I understand that the information in this application will be kept confidential, and only the information required to provide the services for which I am eligible will be disclosed to those who perform the services.**

**I understand that I might be asked to provide additional information necessary for a proper determination of eligibility for ADA priority service.**

**Privacy Statement**

*The information obtained in the application will only be used by the Asotin County PTBA and the Federal Transit Administration for the provision of public transit services. The information will be kept confidential and will not be provided to any other persons or agencies, unless authorized by the passenger and/or their legal guardian.*

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**Signature**

**Date**

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**Signature (if other than applicant)**

**Relationship**

**Date**

## MEDICAL/PROFESSIONAL VERIFICATION

Dear Professional:

You are being asked by \_\_\_\_\_ (applicant) to provide information regarding his/her ability to use our transit system. Federal law requires that Asotin County PTBA provide ADA Priority service to persons who cannot use the fixed route. The information you provide about the noted disabilities will allow us to evaluate this request.

To qualify for ADA Priority service, a person must be unable to use the fixed route due to a physical or mental disability. Please indicate below the nature of the applicant's disability.

Please check your professional area of specialization:

- |                                                    |                                                                    |
|----------------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> Audiologist               | <input type="checkbox"/> Registered Nurse/Licensed Practical Nurse |
| <input type="checkbox"/> Rehabilitation Specialist | <input type="checkbox"/> Physical/Occupational/Speech Therapist    |
| <input type="checkbox"/> Physician                 | <input type="checkbox"/> Independent Living Specialist             |
| <input type="checkbox"/> Optometrist               | <input type="checkbox"/> Psychologist                              |
| <input type="checkbox"/> Social Worker             | <input type="checkbox"/> Other _____                               |

Name \_\_\_\_\_ Title \_\_\_\_\_

Agency \_\_\_\_\_

License # (if applicable) \_\_\_\_\_

Agency address \_\_\_\_\_

Agency phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_





Please specify the disabilities of the applicant.

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What mobility aids, if any, does the applicant use?

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Without assistance, how far can the applicant walk, with their mobility aid?

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What medications are prescribed the applicant that may affect them in extreme heat and/or cold weather?

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Please describe what physical and/or mental conditions exist that limits the applicant's ability to use the fixed route.

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Is the applicant's disability Permanent Temporary

If the applicant's disability is temporary, how long is the expected duration?

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**I hereby certify that the above information is true.**

Name (print) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_