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.

   ____

   ____

   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?**

   ____

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

   ____
   ____
   ____
   ____

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.

____

Signature **Date**

____

Signature (if other than applicant) **Relationship** **Date**

THE FOLLOWING PAGES TO BE COMPLETED BY A MEDICAL PROFESSIONAL

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:

☐ Audiologist
☐ Rehabilitation Specialist
☐ Physician
☐ Optometrist
☐ Social Worker
☐ Registered Nurse/Licensed Practical Nurse
☐ Physical/Occupational/Speech Therapist
☐ Independent Living Specialist
☐ Psychologist
☐ 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 ____________________