Berkshire Regional Transit Authority (BRTA)
1 Columbus Ave Suite 201 Pittsfield, MA 01201
(413) 499–2782 (800) 292–2782

Dear Applicant:

An ADA paratransit application is enclosed.

Please answer all questions. Incomplete applications will be returned and not considered submitted until complete.

Please note this application requires the applicant's signature on pages 6 and 7.

Either mail the application to the address in the application or hand deliver to the office at the address listed.

BRTA certifies individuals for ADA paratransit eligibility in accordance with the Americans with Disabilities Act (ADA) of 1990. Your disability must prevent you from one or more of the following:

- Boarding a regular fixed-route bus, even with the use of a lift or ramp.
- Getting to a bus stop or destination.
- Traveling by bus, including the lack of ability to recognize destinations or follow directions, for reasons other than:
  - inability to speak or limited comprehension of English
  - simple lack of knowledge of schedules or locations
  - new to the area and not knowing how to get around
  - bus takes too long, stops too much, or too many transfers

For questions or assistance in completing your application, please call BRTA at **(413) 499–2782 (800) 292–2782**

Sincerely,

BRTA- ADA Coordinator

Berkshire Regional Transit Authority (BRTA)
1 Columbus Ave Suite 201 Pittsfield, MA 01201
(413) 499–2782 (800) 292–2782
(413) 443-3971 FAX

BRTA ADA PARATRANSIT SERVICE

Request for Certification of ADA Eligibility

The information obtained in this certification will only be used by BRTA for the provision of transportation services. Pertinent information will only be shared with other transit providers to facilitate travel in their areas. The information will not be provided to any other person or agency.

This form must be filled out completely. ***Please type or print.***

1. _____ _____ _____ □ Male
Last name First name Middle Initial □ Female

2. _____
Address Apt No. City State Zip

_____
Mailing Address, if different from above

3. Telephone Number(s) Home_____ Work / Cell _____

4. Date of Birth ___/___/____ Age_____ Social Security Number XXX-XX_____

5. Are you able to use BRTA accessible buses for any of your transportation needs?

□**Yes** □**No** □ **Sometimes** (explain) _____

Please indicate the reason(s) why you are seeking Paratransit eligibility:

□ I can use BRTA buses to go some places, but other places, I can't get to or from the bus stops.
□ I can use BRTA buses sometimes, but only if they are equipped with wheelchair lifts.
□ I can *never* use BRTA buses because: Explain briefly:

_____
_____
_____

6. The disability/disabilities that prevent(s) you from using BRTA fixed route service is/are? You must list the specific condition and/or diagnosis

□ Physical_____

□ Cognitive/Mental _____

Is this condition temporary? ☐Yes ☐No If "Yes," expected duration is until ___/___/___

7. How does this disability prevent you from using fixed route services? Please explain completely. (If necessary, continue on separate sheet) _____

_____

_____

_____

_____

8. Are there any other effects of your disability or other medical conditions of which BRTA needs to be aware? *(If necessary, continue on separate sheet)*

_____

_____

_____

9. Which, if any, of the following aids to mobility do you use? *(Check all that apply.)*

□Support Cane	□Leg Braces	□Walker
□Long White Cane	□Crutches	□Powered Scooter
□Low Vision Aid	□Oxygen Tank	□Powered Wheelchair
□Hearing Aid	□Prosthesis	□Manual Wheelchair

□Other (specify) _____

□Service Animal What type of animal? _____

What function does it provide regarding your transportation? _____

10. If a wheelchair or scooter is used, does it meet the following conditions for our vehicles? Not greater than 30 inches wide and 48 inches long when measured 2 inches above the platform base, and does not exceed 660 pounds when occupied by applicant. These standards are set by ADA to define "common wheelchair". □**Yes** □**No**

NOTE: Wheelchair lifts on paratransit vehicles are calibrated to these standards. Should your mobility aid exceed these measurements you most likely will not be able to access the vehicles.

11. Do you need the help of another person while traveling? □**Yes** □**No**

What type of help do you need? _____

12. How are you currently traveling? □Family/Friends □Cab □Bus □Other _____

Please list the two most common trips you take and how you got there:

Origin:_____ Destination: _____

How did you get there?: _____

Origin:_____ Destination: _____

How did you get there?: _____

13. Can you climb three steps with a hand rail, without help?

□**Yes** □**No** □**Do not know**

14. (a)Have you ever used Fixed-Route buses?

□**No** □**Yes**, *I have used other buses* □***Yes****, I currently use BRTA*

□***Yes****, but I can't any longer due to*: _____

(b) Has anyone ever taught you how to use BRTA buses?

□**No** □**Yes,** from a friend/relative

□**Yes,** from an agency (Name): _____

What mobility skills can you perform? Check the skills:

□ I can travel to and from bus stops □ I can ride all or some routes

□ I can cross streets □ I can read bus schedules

□ I can ride the routes listed: #_____#_____#_____ □Other

(c) Check the items listed below that might help you ride the Fixed-Route bus system:

□Help with trip planning □Bus stops closer to my house

□Help communicating □ Lift accessible buses

□Someone to teach me □Help with transfers

□ Knowing more about the fixed route bus system

□ I would travel if there were accessible fixed bus routes where I need to go

□ Other (please specify) _____

15. Please answer the following questions regarding physical functioning level:

How far can you travel, by yourself, without the help of another person?

Distance in feet _____

How many 9-inch steps can you climb by yourself?

□ 1-3 steps □ 4-6 steps

□ 7-9 steps □ 10-11 steps

□ Over 12 steps □ I cannot climb steps without assistance

Using a mobility aid, equipment, or standing on your own, what is the longest length of time that you can remain standing?

□ 1-15 minutes □ 15-30 minutes

□ 30-45 minutes □ 45-60 minutes

□ Over 60 minutes □ I cannot stand without assistance

How long can you sit by yourself?

□ 1-5 minutes □ 6-10 minutes

□ 11- 15 minutes □ 16-20 minutes

□ Over 20 minutes □ I cannot sit at all because

_____

Do temperature extremes (heat >90degrees; cold <10degrees) impact your disability ☐Yes ☐No ☐Sometimes (explain) _____

16. VISION

Do you have a visual impairment? □**Yes** □**No**

Do you wear corrective lenses (contacts or glasses) □**Yes** □**No**

What is the measured level of your vision?

Without corrective lenses_____ With your corrective lenses_____

Are you certified as legally blind by the Commonwealth of Massachusetts?

□**No** □**Yes** If yes you MUST attach a current and valid copy of your certificate.

17. HEARING

Do you have a hearing impairment? □**Yes** □**No**

Do you wear hearing aids □**Yes** □**No**

What is the measured level of your hearing?

Without hearing aids_____ With your hearing aids_____

Please read through these categories before completing this section and indicate all conditions which affect your ability to use the bus.

A) General Medical Conditions

□ None □ Cancer □ Diabetes
□ Kidney Dialysis □ Organ Transplant □ Pneumonia
□ Other _____

B) Bone and Joint Conditions

□ None □ Joint Replacement (which)_____ □ Arthritis
□ Fusion □ Osteo-arthritis □ Osteoporosis
□ Rheumatoid Arthritis □ Fibromyalgia
□ Amputation (please specify) _____
□ Broken Bone (please specify) _____ When? _____
□ Other _____

C) Brain/Nerves/Muscle Conditions

□ None □ Alzheimer's Disease □ Brain Injury
□ Cerebral Palsy □ Dementia □ Epilepsy
□ Guillian-Barre □ Hemiplegia □ Huntington's Chorea
□ Multiple Sclerosis □ Muscular Dystrophy □ Paraplegia
□ Parkinson's Disease □ Post-polio □ Quadriplegia
□ Spina Bifida □ Stroke (When? _____) □ Vertigo/Dizziness
□ Other _____

D) Heart and Circulatory Conditions

□ None □ High Blood Pressure □ Edema
□Congestive Heart Failure □ Peripheral Vascular Disease □ Angina
□ Heart Attack (when?)_____ □ Heart Surgery (when?)_____
□ Other _____

E) Lung and Breathing Conditions

□ None □ Allergies □ Asthma
□ Cystic Fibrosis □ Emphysema □ Lung Cancer
□ Chronic Obstructive Pulmonary Disease (COPD)
□ Other _____

F) Developmental/Mental Conditions

□ None □ Autism □ Mood Disorder
□ Psychosis □ Thought Disorder □ Brain Injury
□Intellectual Disability (as identified by DSM IV) □ ***Mild*** □ ***Moderate*** □ ***Severe***
□ Other _____

You must attach/include the evaluation/report which verifies the condition. A note or letter from your primary care physician will not be sufficient for this section.

G) If your condition is not listed above please list it/them here.

_____ _____ _____

H) If you checked any of the above conditions (listed in A through G) above how do they affect your ability to use the BRTA Bus?

_____
_____
_____

Do you have a cognitive disability? □**Yes** □**No**

If so, can you:

• Read and understand basic written material? □**Yes** □**No**
• Give addresses and telephone numbers upon request? □**Yes** □**No**
• Recognize a destination or landmark? □**Yes** □**No**
• Deal with unexpected situations or an 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**

Please use the following space to explain in detail what you can or cannot do on your own:

_____
_____
_____
_____
_____
_____
_____
_____
_____

I hereby certify that the information given in this application is correct.

Applicant Signature_____ Date_____

If someone other than the applicant completed this form, or assisted, on behalf of the applicant, that person must complete the following:

Name_____ Daytime phone_____

Relationship to Applicant _____

Agency _____ Address_____

□ Check here if all Program correspondence should be sent to the Agency identified above in care of the address listed above.

Signature_____ Date ___ /___ /_____

Return completed form to:

BRTA - ADA Coordinator
1 Columbus Ave Suite 201
Pittsfield, MA 01201

MEDICAL INFORMATION RELEASE AUTHORIZATION

In order for BRTA to evaluate your request, it may be necessary to contact a medical /clinical professional to confirm the information that you have provided. Please complete the following information and authorization form.

The following health care professional is familiar with my disability and is authorized to provide BRTA all information required to complete this certification.

☐Occupational Therapist ☐Ophthalmologist ☐Physician
☐Physical Therapist ☐Registered Nurse ☐Other _____

Professional's name _____
Address _____
City State Zip Telephone number

Applicant Name (Print) _____

Applicant Signature _____ Date: _____

The client named above has requested BRTA paratransit service. BRTA paratransit service provides transportation to individuals with disabilities who are unable to use the BRTA fixed route (bus) system.

ADA Paratransit Eligibility Standards:

☞Any individual with a disability who is unable, as a result of a physical or mental impairment (including vision impairment), and without the assistance of another individual (except the operator of a wheelchair lift or other boarding assistance device), to board, ride, or disembark from any vehicle on the system which is readily accessible to and usable by individuals with disabilities.

☞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.

I. Only a specific impairment-related condition which prevents the individual from traveling to a boarding location or from a disembarking location is a basis for eligibility under this paragraph. A condition which makes traveling to a boarding location more difficult for a person with a specific impairment-related condition than for an individual who does not have the condition, but does not prevent the travel, is not a basis for eligibility under this paragraph. [49 CFR 37.123(e)(3)(i)]

II. Architectural barriers not under the control of the public entity providing fixed route service and environmental barriers (e.g., distance, terrain, weather) do not, standing alone, form a basis for eligibility under this paragraph. The interaction of such barriers with an individual's specific impairment-related condition may form a basis for eligibility under this paragraph, if the effect is to prevent the individual from traveling to a boarding location or from a disembarking location. [49 CFR 37.123(e)(3)(ii)]

☞ ***Eligibility shall not be based solely on a medical diagnosis of disability. Eligibility shall be based on the ability of the patron to use available fixed route service as described in the criteria above. [Interpretation of 49 CFR 37.123(e)]***

There are many ways that the BRTA can determine eligibility. The process may include functional evaluation or testing of applicants. Evaluation by a physician or health professional may be part of the process, **but a diagnosis of a disability does not establish eligibility**. What is needed is a determination of whether, as a practical matter, the individual can use fixed-route transit under given circumstances.

REQUEST FOR PROFESSIONAL VERIFICATION

This form must be completed by a professional

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 BRTA provide paratransit services to persons who cannot utilize available accessible fixed route (bus) services. Please keep in mind that any condition which makes traveling to or from a boarding/disembarking location, or riding on a fixed route system more difficult or less comfortable, are not reasons for paratransit eligibility. The information you provide will allow us to make an appropriate evaluation of the request and its application to specific trip requests.

Capacity in which you know the applicant: _____

Medical/Clinical Diagnosis of condition causing disability (in layman terms): _____
_____

Is the condition temporary? ☐No ☐Yes ☐Expected duration until _____ /____ /_____

If disability/condition is PHYSICAL in nature, please answer the following questions regarding PHYSICAL functioning level:

How far can the person travel without the assistance of another person?
Distance in feet _____

How many 9-inch steps can the person climb without assistance?

- □ 1-3 steps
- □ 4-6 steps
- □ 7-9 steps
- □ 10-11 steps
- □ Over 12 steps
- □ Cannot climb steps without assistance

Using a mobility aid, equipment or standing on their own, what is the longest length of time that the person can remain standing?

- □ 1-15 minutes
- □ 15-30 minutes
- □ 30-45 minutes
- □ 45-60 minutes
- □ Over 60 minutes
- □ Cannot wait without assistance

How long can the person sit by themselves?

- □ 1-5 minutes
- □ 6-10 minutes
- □ 11- 15 minutes
- □ 16-20 minutes
- □ Over 20 minutes
- □ Cannot sit at all because _____

Which, if any, mobility aid(s) does the person use? _____

Do weather conditions impact the person's disability or health condition such that it prevents him/her from independently getting to and/or from a bus stop? **□Yes □No**

Explain how a particular weather condition interacts with the disability noted.
_____
_____

If the person has a visual impairment: (If certified legally blind, attach copy of state cert.)

Visual acuity with best correction: Right eye _____ Left eye_____ Both eyes _____
Visual fields: Right eye _____ Left eye_____ Both eyes _____

If the person has a hearing impairment:
Hearing level without hearing aids Right ear _____ Left ear_____ Both ears _____
Hearing level with hearing aids Right ear _____ Left ear_____ Both ears _____

If the person has a cognitive disability: Is the person able to do the following:

Give address and telephone numbers upon request? Yes No Sometimes
(explain)_____

Deal with unexpected situations or changes in routine? Yes No Sometimes
(explain)_____

Ask for, understand, and follow directions? Yes No Sometimes
(explain)_____

Safely & effectively travel through crowded and/or complex facilities? Yes No
Sometimes (explain)
_____

Is there any other effect of the disability, and or medication, of which BRTA should be aware? If so, please describe. (If necessary, continue on separate sheet).
_____

_____

_____

_____

Your Name _____
Office Address _____
Office Telephone Number _____
Medical License Number OR Certification # _____

Signature_____

This application must be fully completed.

For additional information about ADA eligibility and the certification process, contact BRTA at **(413) 499-2782.** Return completed applications to: BRTA ADA Coordinator, 1 Columbus Avenue, Suite 201, Pittsfield, MA 01201 or fax (413) 443-3971.