

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

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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.

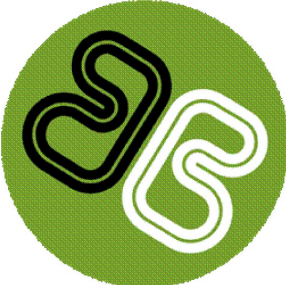
BRTA certifies individuals for ADA paratransit eligibility in accordance with the Americans with Disabilities Act (ADA) of 1990. Your disability must prevent you from one or more of the following:

- 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 \_\_\_\_\_ Email \_\_\_\_\_

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) \_\_\_\_\_

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**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)

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

- |  |                                      |   |
|--|--------------------------------------|---|
| <input type="checkbox"/> Support Cane    | <input type="checkbox"/> Leg Braces  | <input type="checkbox"/> Walker             |
| <input type="checkbox"/> Long White Cane | <input type="checkbox"/> Crutches    | <input type="checkbox"/> Powered Scooter    |
| <input type="checkbox"/> Low Vision Aid  | <input type="checkbox"/> Oxygen Tank | <input type="checkbox"/> Powered Wheelchair |
| <input type="checkbox"/> Hearing Aid     | <input type="checkbox"/> Prosthesis  | <input type="checkbox"/> 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**

- |  |   |                                    |
|--|---|------------------------------------|
| <input type="checkbox"/> None            | <input type="checkbox"/> Cancer           | <input type="checkbox"/> Diabetes  |
| <input type="checkbox"/> Kidney Dialysis | <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Other _____     |   |                                    |

**B) Bone and Joint Conditions**

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> None   | <input type="checkbox"/> Joint Replacement (which)_____ | <input type="checkbox"/> Arthritis    |
| <input type="checkbox"/> Fusion   | <input type="checkbox"/> Osteo-arthritis                | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Rheumatoid Arthritis                           | <input type="checkbox"/> Fibromyalgia                   |                                       |
| <input type="checkbox"/> Amputation (please specify) _____              |   |                                       |
| <input type="checkbox"/> Broken Bone (please specify) _____ When? _____ |   |                                       |
| <input type="checkbox"/> Other _____                                    |   |                                       |

**C) Brain/Nerves/Muscle Conditions**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> None                | <input type="checkbox"/> Alzheimer's Disease  | <input type="checkbox"/> Brain Injury        |
| <input type="checkbox"/> Cerebral Palsy      | <input type="checkbox"/> Dementia             | <input type="checkbox"/> Epilepsy            |
| <input type="checkbox"/> Guillian-Barre      | <input type="checkbox"/> Hemiplegia           | <input type="checkbox"/> Huntington's Chorea |
| <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Muscular Dystrophy   | <input type="checkbox"/> Paraplegia          |
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Post-polio           | <input type="checkbox"/> Quadriplegia        |
| <input type="checkbox"/> Spina Bifida        | <input type="checkbox"/> Stroke (When? _____) | <input type="checkbox"/> Vertigo/Dizziness   |
| <input type="checkbox"/> 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:

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***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**





# 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?**

- |  |  |
|--|--|
| <input type="checkbox"/> 1-3 steps     | <input type="checkbox"/> 4-6 steps                             |
| <input type="checkbox"/> 7-9 steps     | <input type="checkbox"/> 10-11 steps                           |
| <input type="checkbox"/> Over 12 steps | <input type="checkbox"/> 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?**

- |  |   |
|--|---|
| <input type="checkbox"/> 1-15 minutes    | <input type="checkbox"/> 15-30 minutes                  |
| <input type="checkbox"/> 30-45 minutes   | <input type="checkbox"/> 45-60 minutes                  |
| <input type="checkbox"/> Over 60 minutes | <input type="checkbox"/> Cannot wait without assistance |

**How long can the person sit by themselves?**

- |  |  |
|--|--|
| <input type="checkbox"/> 1-5 minutes     | <input type="checkbox"/> 6-10 minutes                    |
| <input type="checkbox"/> 11- 15 minutes  | <input type="checkbox"/> 16-20 minutes                   |
| <input type="checkbox"/> Over 20 minutes | <input type="checkbox"/> 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 \_\_\_\_\_ Date \_\_\_\_\_

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.