

# Link TRANSIT

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Dear Passenger,

Thank you for your interest in Link Paratransit. This service is available to persons that meet the requirements of the Americans with Disabilities Act (ADA) that cannot ride fixed route transit because of your disability. The ADA is a law, which requires accessible transportation for persons with disabilities, which closely matches the service offered by Link Transit. This application will ask questions about your ability to access Link Transit and its facilities.

The ADA was created to assure that all persons with disabilities, who are unable to use the regular fixed route bus service or access fixed route bus stops, have complementary transportation to the regular fixed route bus service. This means that a person who is unable to use the regular bus should be able to travel on the same days, during the same hours, and in the same general area as the fixed route bus travels (within a  $\frac{3}{4}$  of a mile corridor), for a fare, which is not more than twice the one-way adult fare of a fixed route bus ride. Link Transit is designed to meet these requirements. Link Transit and this certification is for those in Burlington, Gibsonville, unincorporated Alamance County between Burlington and Alamance Community College. For transportation in other areas, please call Alamance County Transportation Authority (ACTA) at (336) 222-0565 or visit [www.acta-info.org](http://www.acta-info.org).

According to the ADA, each person who may qualify for paratransit **must** complete an eligibility application form. This form will help determine if you are eligible to use these services based on the definitions of the ADA. The eligibility process is related more closely to your functional ability to use the bus and requires you to answer the enclosed questionnaire very carefully. You are encouraged to have someone help you with the questionnaire if you have questions.

An ADA ID Card with a registration number will be mailed to you within 21 days, if you are determined to be ADA eligible for ADA paratransit service. You will also be notified within 21 days, if you are determined to be ineligible for ADA paratransit service.

If you have any questions about this application, or any part of the eligibility process, you may call me at (336) 222-7351 or 711 for TDD/TTY users through the Relay Service.

Sincerely,



John Andoh  
Interim Transit Manager



**ADA PARATRANSIT CERTIFICATION APPLICATION**

The information obtained in this certification process will be used only by Link Transit for the provision of ADA complementary paratransit services and will not be provided to any other person or agency without prior written approval of the applicant.

**New Application** or  **Recertification**

**APPLICANT INFORMATION (Please print or type)**

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

Address \_\_\_\_\_ Apt # \_\_\_\_\_ Cross St. \_\_\_\_\_

\_\_\_\_\_  
Mailing Address, if different than above

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

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Male  Female

Please provide the name and phone number of a **LOCAL** friend or relative to contact in the event of an emergency:

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

Daytime Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

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

- Manual Wheelchair
- Electric Wheelchair
- Power Scooter
- Cane
- Crutches
- Walker
- Oxygen Tank
- Service Animal
- Other \_\_\_\_\_
- None

2. Is your mobility device oversized?  Yes  No

a. If yes, please explain and advise weight: \_\_\_\_\_  
Some buses may have weight restrictions on their wheelchair lifts or ramps.  
Please call Link Transit for more information.

3. Is your condition temporary?  Yes  No  
If yes, expected duration: \_\_\_/\_\_\_/\_\_\_

4. Does your condition change from time to time due to medications, medical treatments, other?  Yes  No  
If yes, please explain

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**Type of disability:**

5. I have a  **Visual**  **Physical**  **Mental** Impairment

6. **What** is your disability that prevents you from using the fixed route service?

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7. **How** does your disability make it *impossible* for you to use the fixed route service?

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8. How far can you continuously walk **OR** advance your manual wheelchair without the help of another person? (i.e., number of blocks) \_\_\_\_\_

Could you travel further if you stopped to rest?

Yes  No  Sometimes

(If No or Sometimes, please explain why)

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9. Have you ever used any of these transit services? Check all that apply:

Fixed Route  Paratransit  ACTA  Other \_\_\_\_\_

10. How many blocks from your residence is the nearest accessible bus stop?

Less than 1 Block  2 to 4 Blocks  4 or more  Don't know

11. Can you independently get on and off a lift/ramp equipped bus?

Yes  No  Sometimes  Don't know

(If No or Sometimes, please explain why)

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12. Is your ability to use public transit affected by weather or environmental/architectural barriers that block your path of travel? (e.g. temperature extremes, no sidewalks, lack of signal lights at a busy intersection, etc.)

Yes  No (If Yes, please explain why)

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13. Can you ask for, understand, and follow directions?

Yes  No  Sometimes

(If No or Sometimes, please explain why)

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14. Can you cross a busy intersection?

Yes  No  Sometimes

(If No or Sometimes, please explain why)

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15. If you are approved for Paratransit Services will you require a personal care attendant?

Yes  No

**Certification of Applicant**

I hereby certify that, to the best of my knowledge, the information I have given in this application is correct and the application will be returned if it is not complete.

I understand that the results of the review will be based on my ability to use the fixed route system. Verification of my disability by my physician or health care professional, identified below, does not guarantee my eligibility for ADA certification of paratransit service.

**Signature of Applicant** \_\_\_\_\_

**Date** \_\_\_\_\_

*If someone other than the applicant completed this application, the following information must be provided.*

Name of person completing the application \_\_\_\_\_

Relation to the applicant \_\_\_\_\_

Daytime phone # \_\_\_\_\_

**Please return this application once completed to:**

**Link Transit**

**Attn: Transit Manager**

**234 East Summit Avenue**

**Burlington, NC 27216**

**Fax: (336) 222-5004**

**Email: [info@linktransit.org](mailto:info@linktransit.org)**

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I hereby authorize you to **release any information necessary to** determine **my eligibility** for ADA Paratransit service provided by the Link Transit. Link Transit has assured me that the requested information will be held in strictest confidence, and will be used only to determine my eligibility for paratransit service.

**Identification of Physician or Health Care Professional**

(Please type or print clearly)

Name and Title of Professional \_\_\_\_\_

Address \_\_\_\_\_,  
(Number and Street) (City) (Zip Code)

Agency \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

**Applicant Information**

Date of Birth \_\_\_\_\_ SSN # (Last four) \_\_\_\_\_

**Signature of Applicant** \_\_\_\_\_ **Date** \_\_\_\_\_

**Printed Name of Applicant** \_\_\_\_\_

## MEDICAL & SOCIAL SERVICE AGENCY PROFESSIONAL VERIFICATION FORM

To process this application, Link Transit needs information about the effects of the applicant's disability on his/her **functional capability** to ride the regular fixed route bus service. This information is necessary to determine whether he/she is eligible for paratransit service under the regulations of the Americans with Disabilities Act (ADA).

The information you provide in this form will aid the Link Transit in making an ADA eligibility determination. For the benefit of the applicant, please answer the questions as fully and accurately as possible. All information will be kept confidential.

The individual's condition must **prevent** travel on a fixed bus route, either all of the time, temporarily, or only under certain circumstances. Disability alone and distance to and from a bus stop do not, by themselves, qualify a person for paratransit service. **Inconvenience, decreased comfort, and/or pain are not a basis for qualification.**

**(Please type or print clearly. Do NOT use ICD-9 or DSM codes.)**

Applicant's Name \_\_\_\_\_

Capacity in which you know the applicant \_\_\_\_\_

Medical diagnosis \_\_\_\_\_

\_\_\_\_\_ Date of Onset \_\_\_\_\_

Prognosis \_\_\_\_\_

1. Does the applicant use any of the following aids for mobility?

(Check all that apply).

- |  |  |
|--|--|
| <input type="checkbox"/> Manual Wheelchair       | <input type="checkbox"/> Electric Wheelchair |
| <input type="checkbox"/> Power Scooter           | <input type="checkbox"/> Cane                |
| <input type="checkbox"/> Crutches                | <input type="checkbox"/> Walker              |
| <input type="checkbox"/> Personal Care Attendant | <input type="checkbox"/> Service Animal      |
| <input type="checkbox"/> <b>Other</b> _____      | <input type="checkbox"/> None                |

2. What category is the applicant's disability?

- Visual**       **Physical**       **Mental** Impairment

3. Applicant's Height \_\_\_\_\_ Weight \_\_\_\_\_

4. Is the applicant's condition temporary? \_\_\_\_Yes      \_\_\_\_No

If Yes, expected duration: \_\_\_\_/ \_\_\_\_/ \_\_\_\_

5. Can the applicant wait outside without assistance for 15 minutes?

- Yes       No

