

**PART A APPLICANT INFORMATION (PLEASE PRINT)**

Please complete the following information. Please answer all questions completely.

Date: \_\_\_\_\_

Please check one: First Application \_\_\_\_\_ Re-certification Application \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Street Address \_\_\_\_\_

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

Home Phone Number ( ) \_\_\_\_\_ Cell Phone Number ( ) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Email Address for correspondence (Optional): \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone Number: ( ) \_\_\_\_\_ Relationship \_\_\_\_\_

Closest bus stops to your residence. \_\_\_\_\_

(If you are not sure, please call (XXX) XXX-XXXX)

Name of subdivision or apartment complex: \_\_\_\_\_

Nearest major intersecting street: \_\_\_\_\_

Nearest cross street to your residence: \_\_\_\_\_

List the Medical Names of Your Disabilities or Medical Conditions	Is the Condition Permanent?	Duration of Condition	Medications taken for the Condition

1. Please describe how your physical or mental condition limits your ability to access the regular bus stop, ride the bus or transfer to another regular. Please be specific.

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2. Do you have a **Cognitive Disability**? (Have you ever been diagnosed with Traumatic/ Non-Traumatic Brain Injury, Mental Retardation, Borderline Intelligence, Down’s syndrome, Autism, etc.?) Yes  No

3. Do you experience any of the following? Please check all that apply:

Panic Attacks	<input type="checkbox"/>	Easily Agitated or Angered	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	Easily Wander Off	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
Delusions	<input type="checkbox"/>	Visual Impairment	<input type="checkbox"/>
Paranoia	<input type="checkbox"/>	Short Term Memory Loss	<input type="checkbox"/>
Confusion	<input type="checkbox"/>	Long Term Memory Loss	<input type="checkbox"/>
Hear Voices	<input type="checkbox"/>	Cannot Identify Pictures	<input type="checkbox"/>
Inappropriate Behaviors	<input type="checkbox"/>	Cannot Read or Write	<input type="checkbox"/>
Easily Taken Advantage of by Others	<input type="checkbox"/>	Difficulty Understanding Written or Verbal Instructions	<input type="checkbox"/>

4. If you experience **Seizures**? Please check all that apply and  
 Grand Mal  Petit Mal  Temporal Lobe  Epileptic Lobe

5. When having a seizure, I: Please check all that apply:  
 Am Difficult to Arouse  Black Out  Fall Asleep  
 Need Immediate Medical Attention  Stare Blankly into Space

6. How often do they occur? \_\_\_\_\_

7. Are you currently taking medication to control them? Yes  No

8. Do you have a **Visual Impairment** (to include Blindness)? Yes  No

If yes, please check all that apply:

- I wear contacts or glasses.
- I can recognize my stop if announcements are made.
- I am legally blind and cannot distinguish my appropriate stop, disembark, and navigate the route to my destination. I do not use a guide dog or other service animal, or any assistive device.
- I use a guide dog or other service animal, but I need paratransit to get to/from destinations that I cannot safely travel to on the route.
- I can easily hear and recognize environmental sounds that help me to determine the traffic flow patterns.
- I cannot easily hear environmental sounds that help me to determine traffic flow.
- I cannot always get out of the roadway before the traffic signal changes.
- I require a sighted guide to assist me with the following tasks: \_\_\_\_\_

\_\_\_\_\_

9. Do you have a **Mental/Psychological Disability**? Yes  No  If yes, please state the disability and explain how it affects you. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

10. Are there any other physical or mental disabilities that impact your **FUNCTIONAL ABILITY** to ride the regular fixed route, accessible bus service? (Example: difficulty with getting to the bus, waiting at the stop for the correct bus, boarding the bus, knowing when you get to your stop and notifying the driver that you need to get off.) Yes  No  If yes, please be specific. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

11. Can you wait at a bus stop that **DOES NOT** have seats?

Yes  No  If no, please be specific. \_\_\_\_\_

\_\_\_\_\_

12. Can you wait 20 minutes at a NICE bus stop that **DOES** have seats and a shelter? Yes  No  If no, please be specific. \_\_\_\_\_

\_\_\_\_\_

13. Can you wait 20 minutes at a LINK TRANSIT bus stop unassisted? Yes  No  If no, please be specific \_\_\_\_\_

14. How far can you walk without the assistance of another person? Please check.  
 Less than one block                       3-4 blocks                       Over 6 blocks  
 1-2 blocks                                       5-6 blocks                       I don't know

15. Do you require a ramp or lift in order to board/exit the bus? Yes  No

16. Do you use a mobility device to travel? Yes  No  Please check all that apply.  
 White Cane                       Orthopedic Cane (three or four prong base)  
 Standard Cane                       Walker                       Braces                       Crutches  
 Manual Wheelchair                       Motorized Wheelchair                       Scooter  
 Respirator/Oxygen                       Service/Guide Animal Describe: \_\_\_\_\_

17. Do you require a personal care assistant (PCA) to travel with you to provide transportation assistance? Yes  No  If yes, please explain the specific assistance you require. \_\_\_\_\_

18. If you do not require a personal care assistant for bus travel, are you required to be met by a caregiver when exiting the bus? Yes  No

19. If the bus arrives at your destination and the caregiver is not there to assist you off the bus, who must be contacted?

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

Telephone: \_\_\_\_\_

20. Are there situations when your caregiver will not be required to meet the bus? Yes  No  If yes, please explain. \_\_\_\_\_

21. Please check all that apply to you:

- I am able to board, ride, and exit a regular fixed route, accessible bus.
- I can cross the street.
- I can step on and off the sidewalk.
- I can stand on a moving bus, holding the handrail, if no seat is available.
- I can use a telephone to get bus schedule information.
- I can find my way to the bus stop after being shown where it is based.
- I can transfer to another bus or train after being shown where it is based.
- I can hear and understand the automatic announcement system on the bus.
- I need assistance understanding and navigating the fixed route system.
- I do not have the stamina to travel long distances.

Please explain those items checked above. \_\_\_\_\_



**PART B: LICENSED PROFESSIONAL VERIFICATION**

Dear Licensed Professional:

The Americans with Disabilities Act (ADA) of 1990 is a civil rights bill prohibiting discrimination against people with disabilities. In accordance with the Act, LINK Transit offers a door-to-door bus service for those who cannot use the regular fixed-route buses.

Passengers must be certified eligible in order to use the curb-to-curb bus service. Applicants may be found eligible for this bus service for some trip requests but not for all trips they request. Eligibility is based upon a functional inability to use the regular transit service.

Categories of eligibility for LINK’s paratransit service are as follows:

- Persons who are unable to board, ride, or disembark from a fixed-route bus, regardless of their ability to get to a bus stop.
- Persons with specific impairments who cannot travel to a bus stop to board the fixed-route bus, or travel to their final destination after disembarking from the fixed-route bus.

All regular fixed-route buses are equipped with a ramp or lift for people who use a wheelchair or cannot climb stairs.

The information you provide, along with the applicant’s information, will enable us to make an appropriate determination. All information will be kept confidential.

If you have completed Part A of this application you cannot also verify Part B. Persons completing Part B must be licensed in the State of North Carolina.

Thank you for your assistance.

**PART B: LICENSED PROFESSIONAL VERIFICATION**

Please make certain that responses are legible.

1. What disability or conditions prevents the applicant from riding the regular fixed route bus? Explain in **detail** the applicant’s clinical diagnosis pertaining to physical, developmental, cognitive, visual or other disability.

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2. Is the condition temporary?  Yes  No.
3. What is the expected duration of the condition? \_\_\_\_\_ months
4. Is the applicant able to travel to and from the bus stop?  Yes  No.

**Check all that apply:**

- Cannot negotiate areas without sidewalks.  Cannot negotiate steep terrain.
  - Cannot step on/off a curb.  Cannot cross a busy intersection.
  - Cannot tolerate  Heat  Cold  Humidity  Poor Air Quality
  - Cannot locate bus stop  Visually  Cognitively
  - Cannot stand at a bus stop for  10 minutes  20 minutes  30 minutes
5. Is the applicant able to accomplish the follow task without assistance?
- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Find his/her way between familiar locations                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Grasp coins, passes, railings and handles                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Signal the bus driver to get off the bus at the appropriate stop | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Communicate important information upon request                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ask for, understand and follow directions                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Travel 200 feet (1 city block)                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Travel ¼ mile (3 city blocks)                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Travel ½ mile (6 city blocks)                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Deal with unexpected situations                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Safely travel through crowded facilities                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

6. Describe the applicant's visual impairment. Mark all that apply.
- Totally Blind  Legally Blind  Glaucoma  Macular degeneration
- Retinal Detachment  Retinopathy  Cortical Blindness  Cataracts
- Other \_\_\_\_\_

7. Please Print Name and Title of Health Care Professional
- Full Name: \_\_\_\_\_
- Title: \_\_\_\_\_
- Clinic/Business: \_\_\_\_\_
- Street Address: \_\_\_\_\_

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

Telephone: Fax No.: \_\_\_\_\_

E-mail (optional): \_\_\_\_\_

Professional License, Registration or Certification Number: \_\_\_\_\_

Agency Issuing License/Certification: \_\_\_\_\_

I have reviewed all of the information contained in this application and hereby certify that all the information is true and correct to the best of my knowledge and ability. I certify that the applicant named herein, is under my professional care. I hereby swear and affirm that the applicant is disabled as indicated.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Additional Comments:

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