

Williamsburg Area Transit Authority - WATA
ADA Complementary Paratransit Service Application

ADA Complementary Paratransit service is a shared-ride, origin-to-destination transportation service for customers who are unable, because of disability, to use the accessible fixed-route bus system. This application will help us to determine your eligibility for this specialized service.

General Information (Please Print)

First Name _____ Middle Initial _____

Last Name _____

Street Address _____ Apt/Bldg. # _____

Mailing Address (if different) _____

City _____ State _____ Zip _____ Country _____

E-Mail _____

Phone (daytime) _____ Emergency Phone: _____

Date of Birth (month/day/year) _____ Sex (M/F) _____

How would you like written materials sent to you in the future?

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> Regular Print | <input type="checkbox"/> Large Print | <input type="checkbox"/> Audio Recording |
| <input type="checkbox"/> Braille | <input type="checkbox"/> E-Mail | |

Name and phone number of a friend or relative we can call if we are unable to reach you at your regular number:

Name _____

Relationship _____ Phone # _____

Disability and Mobility Equipment Information

What type or types of disabilities prevent you from using the fixed-route bus service?

- | | |
|---|--|
| <input type="checkbox"/> Physical Disability | <input type="checkbox"/> Visual Impairment/Blindness |
| <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> Mental Impairment |
| <input type="checkbox"/> None | <input type="checkbox"/> Other |

Please describe your disability and limitations from using regular bus transit:

If this is a temporary disability or health condition, how long do you expect it to prevent you from using the bus? _____

Please check all mobility aids or equipment you use:

- | | |
|---|--|
| <input type="checkbox"/> White Cane | <input type="checkbox"/> Powered Wheelchair |
| <input type="checkbox"/> Cane for the blind | <input type="checkbox"/> Communication Board |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Powered Scooter |
| <input type="checkbox"/> Leg Braces | <input type="checkbox"/> Manual Wheelchair |
| <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Portable Oxygen | <input type="checkbox"/> Service Animal |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> I do not use any of these mobility aids. | |

Do you need to bring someone with you to help when you use the bus or van service (“personal assistant” or “personal care attendant”)?

- Yes, sometimes Yes, always No

Ability to Use Fixed-Route Buses

Please note, all WATA buses are low-floor kneeling, have no steps, and are fully accessible for mobility aids, (i.e., walkers, wheelchairs, etc.) and provide the greatest freedom to those who can use it. What best describes your ability to use the WATA fixed-route buses?

- I cannot get to and from bus stops because of the distance.
- I have a disability or condition which prevents me from riding the buses if the weather is too hot or too cold.
- I have difficulty understanding or remembering things I would have to do to use the bus.
- My disability or health condition can change from day to day. I can ride the fixed-route buses when I am feeling well, but not at other times.
- I can get to and from bus stops only if there are curb-cuts and sidewalks.
- I can never use the fixed-route buses by myself.
- I am not really sure if I can use the fixed-route buses.
- I am not able to use the fixed-route buses for other reasons. ***Please explain:***

Have you ever had training on how to use the WATA bus?

Yes No

Would you like free training?

Yes No

Where Do You Go and How Do You Get There Now?

Name the three places you may go and how you get there now.

1. Where do you go? _____

Address _____

How often do you go there? _____ How do you get there now? _____

2. Where do you go? _____

Address _____

How often do you go there? _____ How do you get there now? _____

3. Where do you go? _____

Address _____

How often do you go there? _____ How do you get there now? _____

Do you currently use the fixed-route buses at all?

No Yes. Which routes? _____

When was the last time you used the fixed-route buses?

If you used the fixed-route buses in the past but have stopped using them, please explain:

I understand the purpose of this form is to determine if I am eligible to use Paratransit door-to-door services. I certify that the information provided in this application is correct. I understand that falsification of information could result in a loss of Paratransit services. I agree to notify WATA if I no longer need to use Paratransit services or if my condition changes.

Signature of Applicant or Responsible Party

Date

If someone assisted in completing this application, please provide the following information:

Print name _____ Relationship to applicant _____

Address _____

Agency _____ Phone _____

WATA will review your application and respond within 21 days of receipt of a completed application. The review process will be suspended if there is no response to requests for additional information from the applicant or health professionals. If we cannot respond within 21 days, you will be eligible to use the service until a determination is made.

Eligibility determinations include the following findings: 1. Full Eligibility, 2. Partial Eligibility or 3. No Eligibility. Individuals denied eligibility for service may appeal the decision. A description of the appeals process will be included with the denial letter to the applicant.

Additional Information

In order for WATA to evaluate your request for eligibility, it may be helpful for us to contact a professional who is familiar with your health condition or disability and your functional abilities. Please list one or two professionals that we can contact. *Examples include: Family Physician (M.D. or D.O.), Independent Living Specialist, Ophthalmologist, Physical Therapist, Rehabilitation Specialist, Psychiatrist, Occupational Therapist, Licensed Social Worker, Psychologist, Orientation and Mobility Instructor, Registered Nurse, Case Manager.*

Name of qualified professional _____

Type of professional _____ Professional's agency _____

Address _____ Phone number _____

Name of qualified professional _____

Type of professional _____ Professional's agency _____

Address _____ Phone number _____

Authorization for Release of Information

I hereby authorize the above named professionals to provide information about my disability and ability to use WATA services and/or persons assisting WATA in determining my eligibility for Paratransit service. I understand that this information will be used solely for the purpose of determining my eligibility for Paratransit service and that all medical information about my disability will be kept confidential.

I also understand that, at no expense to me, WATA may require that I participate in an in-person evaluation of my travel skills and agree to such an evaluation if one is necessary. If I fail to show for my in-person evaluation, Paratransit service will be suspended until I arrange and complete an evaluation.

Signature of Applicant or Responsible Party

Date