City of Sandusky
Sandusky Transit System (STS)
Application for ADA Paratransit Service

The Americans with Disabilities Act of 1990 (ADA) is a civil rights bill that bans discrimination against people with disabilities. Under the ADA, transit agencies operating a fixed-route system must provide a comparable travel system for people with disabilities who cannot use the fixed-route system.

What is Paratransit Service?

Paratransit is the transportation service of the Sandusky Transit System (STS) for persons with a functional disability who are unable to use STS fixed-route bus service for some or all of their trips due to the effects of their disability. Paratransit is a “Shared-Ride” service that operates at the same times and in the same areas as the fixed-route buses and trains with very few exceptions. STS Paratransit operates in full compliance with the Americans with Disabilities Act. Eligibility is not based solely on a diagnosis or type of disability.

Individuals are eligible based on 3 categories:

1. **Inability to navigate the system independently.**

   Any person who is unable to board, ride, or exit any accessible STS fixed-route bus without the assistance of another person, other than the operator, as a result of a physical, visual, or mental disability.

2. **Lack of accessible vehicles, stations, or bus stops.**

   If accessible vehicles are not available or if a boarding or disembarking location is not accessible on the routes that the customer wishes to travel on.

3. **Inability to reach a boarding point or final destination.**

   Any person with a functional disability who has a specific impairment related condition that makes it **impossible** for them to travel, all or some of the time, to a STS fixed-route bus stop boarding location.

The Paratransit service area is defined as up to ¾ mile on either side of an existing bus route. Service is available on the same days and times as fixed-route service of the requested route. If you have a disability that prevents you from using the regular fixed-route service, you may be eligible for Paratransit.

ADA Paratransit service is considered a premium service and agencies by law can charge a fare that is double the standard fixed-route fare.

STS Paratransit Service-

Is Not- a social service sponsored transportation program or for special event group trips. It is not designed to meet the needs of **every** disabled person; some people may require more service or assistance than STS Paratransit can provide.

Is Not- for individuals who can use the regular STS buses but do not want to.

Is - **Origin to Destination and not** door through door service. Drivers do not escort passengers inside buildings. They will escort passengers to and from outer doors only.

Is Not- responsible for custodial care of our passengers.

Does Not- provide mobility aids for Passengers.

What is STS Fixed-Route Service?

- STS buses operate along fixed-routes on an established schedule.
- Vehicles are 100% accessible with lifts, ramps available on all routes.
- Vehicles have priority seating for people with disabilities and seniors.
- Vehicles have stop announcements (by the operator).
- Vehicles have securement devices for mobility aids.
- Reduced fares are available for seniors and persons with a qualified disability.
- STS fixed-route service operates in full compliance with the Americans with Disabilities Act (ADA).

To help us determine your eligibility for ADA Paratransit Service, please fill out the enclosed application as completely and thoroughly as possible.

All applications must be completed in their entirety or they will be returned to the applicant for completion before being processed.

To Apply:

1. You or your designee must fill out pages 4-11 **COMPLETELY**. Your licensed medical health professional must complete pages 14-16 or 17-18 depending on your disability.

2. Mail your completed application to:
   STS-ADA Eligibility
   240 Columbus Ave
   Sandusky, Ohio 44870

3. Once your completed application has been received, and if additional information is needed, STS may contact you to schedule an "Eligibility & Assessment" interview.

4. After the completion of the "Eligibility & Assessment" process, you will be notified of your ADA Paratransit eligibility status within 21 calendar days of receiving the complete application. If determined eligible, you will be provided with instructions on obtaining your ADA Paratransit Letter.

What you should bring an interview?

- A valid, state issued photo identification card
- A valid Medicaid identification card (if applicable)
- Mobility device that will be used when riding on Paratransit (cane, service animal, wheelchair, power chair, etc.)

The Sandusky Transit System (STS)
Application for Paratransit Service

Please complete this application as thoroughly as possible and to the best of your ability. If there are questions that you cannot answer, or if you need assistance to complete this form, please call **Customer Service at (419) 627-0740**. To be considered complete, every question on the application must be answered. If not, it will be returned to you for completion. Your licensed physician or health care professional must complete Part VIII and/or IX of this application, the Medical Professional Verification.

PART I: APPLICANT INFORMATION

PLEASE TYPE or PRINT IN BLUE OR BLACK INK

☐ New Applicant ☐ Recertification - ID#_____

Name:_____
First M.I. Last

Street Address: _____

City:_____State:_____Zip: _____

Day Phone: _____ Evening Phone: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Are you a Medicaid recipient? ☐ Yes ☐ No

Emergency Contact Person: _____

Day Phone:_____Evening Phone: _____

Relationship to Applicant: _____

PART II: DISABILITY AND HEALTH CONDITION INFORMATION

1. What disability have you been diagnosed with?

_____

_____

2. Date of diagnosis: _____

3. Does your disability prevent you from using the regular bus or rail service?

☐ Yes ☐ No If yes, please explain:

_____

_____

4. Is your disability considered permanent? ☐ Yes ☐ No

If no, how long do you expect to have this disability?

_____

5. Does your disability change from day to day or seasonally? ☐ Yes ☐ No

If yes, please explain:

_____

_____

6. Does your disability make it difficult for you to understand and remember how to find your way to and from the bus stop or rail station? ☐ Yes ☐ No

If yes, please explain:

_____

_____

PART III: MOBILITY INFORMATION

7. Do you currently use any mobility aids or specialized equipment? ☐ Yes ☐ No

   If yes, please select all that apply:

☐ Brace(s)	☐ Manual wheelchair	☐ Scooter
☐ Cane	☐ Motorized Wheelchair	☐ Service Animal
☐ Communication Board	☐ Portable Oxygen	☐ Walker
☐ Crutches	☐ Prosthesis	☐ White Cane

   ☐ Other (please specify): _____

8. If you use a wheelchair or scooter, is the combined weight of you and the device over 600 pounds? ☐ Yes ☐ No ☐ Not applicable

9. If you use a wheelchair or scooter, does your residence have a wheelchair ramp? ☐ Yes ☐ No ☐ Not applicable

   If no ramp, how many steps? _____

   If more than one step, how do you transport your wheelchair to the street level?

   _____

   _____

NOTE:

- Lifts on Paratransit vehicles are designed to accommodate mobility aids that are up to 53 inches long, up to 33.5 inches wide and no more than 600 pounds when occupied. If your mobility device exceeds these dimensions or weight, the vehicle may not be able to accommodate your mobility aid. Lifts/ramps on some fixed route vehicles have a minimum design load of 600 pounds and may not be able to accommodate heavier mobility aids (49 CFR Part 38).

- Your trip origin and destination must be accessible by ramp or lift. IF NOT ACCESSIBLE, please have someone available to assist you up and down steps. Drivers are not permitted to assist riders who use wheelchairs up or down stairs or push them up or down ramps.

PART IV: CURRENT TRAVEL INFORMATION

10. Have you ever used the regular fixed route bus service? ☐ Yes ☐ No

    If no, why not?

    _____

    _____

11. Do you currently use the fixed regular fixed route bus service?

    ☐ Yes ☐ No If yes, which routes do you use?

    _____

    _____

    If yes, what difficulties do you have when riding the bus service?

    _____

    _____

    _____

12. Do you need someone to accompany you when you travel outside the home (i.e. Personal Care Attendant, someone designated or employed to specifically help with personal needs)? ☐ Yes ☐ No

    If yes, what assistance does that person provide for you?

    _____

    _____

13. How many blocks is the closest bus stop to your home? (please give the approximate number of blocks or distance)

    _____

14. Can you get to and from the bus stop nearest to your home by yourself?

☐ Yes ☐ No

If no, explain why not?

_____

_____

15. Does weather affect your ability to use the bus system? ☐ Yes ☐ No

If yes, please explain.

_____

_____

16. Have you ever received training on how to use the bus system?

☐ Yes ☐ No

If yes, which agency provided the training and when?

_____

If yes, did you successfully complete the training? ☐ Yes ☐ No

17. Would you like to receive travel training? ☐ Yes ☐ No

18. How would you describe the terrain where you live?
(e.g., flat, steep hills, gradual sloping hills, etc.)

_____

19. Are there sidewalks in your neighborhood? ☐ Yes ☐ No

20. Are there sidewalks at the nearest bus stop? ☐ Yes ☐ No

21. List the 3 most frequent destinations you travel to and how you currently get there:

	Location 1	Location 2	Location 3
Destination Name			
Address			
How frequently do you travel there (within a month)?			
How do you currently get there?			

22. How many blocks are from your residence to the nearest bus stop?

☐ Less than 2 blocks ☐ 2 to 4 blocks ☐ Not sure
☐ 5 to 7 blocks ☐ More than 7 blocks

23. How many blocks are from your most frequent destination to the nearest bus stop?

☐ Less than 2 blocks ☐ 2 to 4 blocks ☐ Not sure
☐ 5 to 7 blocks ☐ More than 7 blocks

PART V: APPLICANT CERTIFICATION

I understand that the purpose of this application is to determine if I am eligible for STS's Paratransit services and that STS staff may need to talk with me later to get more information. I understand that I may be required to attend an in-person interview or functional ability assessment as part of this application process.

By signing this application, I certify that I have been truthful in answering this form and that the information that I have provided is correct to the best of my knowledge. I understand that falsification of this information could result in a loss of Paratransit service.

I agree to notify STS if I no longer need to use Paratransit service.

Applicant Signature	Date

OR, if applicant is unable to sign:

By signing here, you are verifying that you are authorized to represent the applicant stated in this application.

Authorized Representative Printed Name	Relationship to Applicant
Authorized Representative Signature	Date

PART VI: APPLICANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize the professional listed below to release to STS information about my disability and health condition and its effect on my ability to travel on STS bus system. I understand that I may revoke this authorization at any time.

All medical information, that you or your health care professional provides, will be kept confidential to the extent permitted under the law, except that the information may be shared with other agencies or professionals involved in the determination of your eligibility.

Licensed Medical Professional Information:

_____

First Name Last Name Title (e.g. MD, NP, PA)

_____

Telephone Number Agency/Organization

_____ _____

Applicant or Authorized Signature Date

PART VII: NOTICE TO HEALTH CARE PROFESSIONAL

Paratransit "Origin-to-Destination" Service

To be eligible for Paratransit service, a person must have a medically documented disability that limits their functional abilities to ride fixed-route (bus system). If the disability prevents a person from using a regular bus, with lift/ramp-equipment some or all of the time, they may be eligible for Paratransit.

Paratransit eligibility is broken into three categories:

1. Inability to navigate the system independently, due to a physical or mental impairment.
2. Lack of accessible vehicles, stations, or bus stops.
3. Inability to get to and/or from a bus stop or station.

Federal Law requires that the Sandusky Transit System (STS) provide Paratransit services to persons who cannot use our transit system. The information you provide in the attached Professional Verification will allow STS's representatives to make an appropriate evaluation of the applicant and determine how we may best meet their needs.

Your evaluation of each person must be based solely upon their functional abilities to use regular fixed-route transit service. Your verification should consider only the presence of a disabling condition, not the applicant's age or economic status. Please exercise care in evaluating applicants for this service. False verification could result in travel limitation for persons legitimately qualified to use Paratransit.

PLEASE NOTE: This does not include persons who find it uncomfortable or inconvenient to get to and from bus stops.

If you have any questions about the application or the review process, please contact the Sandusky Transit System at (419) 627-0740.

If you must disclose protected health information about the applicant, we have provided the applicant with an Authorization to Disclose Protected Health Information and have asked them to provide an executed copy to your office with this application.

List of Medical Health Professionals appropriate for the following disabilities:

The following medical professional verification form must be completed by a Licensed Medical Professional or Primary Care Physician

Disability	Licensed Professional Health Physician
Back & Spinal Related Injuries	Rheumatologist
Blood Disorders	Hematologist
Cancer	Oncologist
Dementia	Neurologist, Psychiatrist
Diabetes	Endocrinologist/Internist
Digestive Impairment	Gastroenterologist
Extremities	Orthopedist, Physical Therapist, or Rheumatologist
Hearing Impairments	Audiologist or Otolaryngology
Heart Impairments	Cardiovascular
Intellectual Disability	Special Education Teacher/Guidance Counselor (students only), Psychiatrist, or Psychologist
Musculoskeletal	Orthopedist, Rheumatologist
Neurological Impairment (Tourette's, MS, Epilepsy, Head Trauma)	Neurologist
Psychiatric/Mental Impairment	Psychiatrist or Clinical Psychologist
Respiratory	Pulmonologist
Speech Impairment	Speech Pathologist
Vision Impairment	Ophthalmologist/Optometrist
Other Disabilities	Licensed Physician or Medical Professional

All Disabilities must be certified by a Licensed Medical Physician as described above.

PART VIII: MEDICAL PROFESSIONAL VERIFICATION

To be completed by your Licensed Medical Physician or Health Care Professional

PLEASE TYPE OR PRINT CLEARLY

Name of applicant: _____

Date of applicant's last visit: _____

Medical diagnosis of disability:

_____

_____

Please discuss the impact this disability has on the applicant's ability to function:

_____

_____

_____

1. Is disability/condition permanent? ☐ Yes ☐ No
   If temporary, when will applicant be able to resume normal travel patterns?
   Date:_____/_____/ _____

2 Is disability/condition intermittent? ☐ Yes ☐ No

3. Under what circumstances does disability/condition flare-up?

   _____

   _____

   _____

4. Does the applicant have the mental capacity, visual and/or hearing ability to:

   Give addresses and phone numbers?..... ☐ Yes ☐ No
   Recognize a destination or landmark? ..... ☐ Yes ☐ No
   Deal with unexpected change in routine? ..... ☐ Yes ☐ No
   Ask for, understand and follow directions? ..... ☐ Yes ☐ No
   Safely travel through crowded/complex facilities?..... ☐ Yes ☐ No

5. Are there any other medical conditions which STS should be aware of? ☐ Yes ☐ No
If yes, explain:

_____

_____

6. How far can the applicant walk without assistance?
   - ☐ Less than one city block? (200ft.)
   - ☐ If more than one city block, how many blocks? _____

7. Can the applicant walk up 3 stairs (12-14 inches) without assistance? ☐ Yes ☐ No

8. Can applicant grip a handrail? ☐ Yes ☐ No

9. Does the applicant use a mobility device? Please check all that apply:

☐ Brace(s)	☐ Manual wheelchair	☐ Scooter
☐ Cane	☐ Motorized Wheelchair	☐ Service Animal
☐ Communication Board	☐ Portable Oxygen	☐ Walker
☐ Crutches	☐ Prosthesis	☐ White Cane

☐ Other (please specify): _____

10. Does the disability prevent the applicant from getting to/from and/or riding the bus system?
☐ Yes ☐ No If yes, explain.

_____

_____

11. How does this condition affect the individual's ability to use fixed-route bus service?

_____

_____

_____

12. Does weather impact applicant's ability to travel? ☐ Yes ☐ No
If yes, please explain weather conditions and effects?

_____

_____

_____

13. Does applicant require a personal care attendant (Someone to travel with him/her)?
☐ Yes ☐ No

THIS CERTIFICATION HAS BEEN COMPLETED BY A LICENSED MEDICAL PROFESSIONAL

Licensed Medical Professional Information:

First Name Last Name Title (e.g. MD, NP, PA)

License/Certification number: _____

Which hospital/agency are you affiliated with? _____

Hospital/Agency name: _____

Address: _____

City:_____State:_____Zip: _____

Office phone #:_____Fax #: _____

I certify that the information contained in this application is true and correct to the best of my knowledge and ability. I hereby verify that the diagnosis of disability listed has been reviewed by me, is accurate and true, and represents the current physical and/or mental condition of the applicant named in this form.

Signature_____ Date:_____/_____/ _____

PART IX: MENTAL HEALTH PROFESSIONAL VERIFICATION

Cognitive Impairment Disability: to be completed by your Psychologist or Psychiatrist

PLEASE TYPE OR PRINT CLEARLY

Name of applicant: _____

What is the applicant's specific disability or impairment?

_____

_____

1. How does this condition affect the individual's ability to use fixed-route bus service?

_____

_____

2. Does the disability prevent the applicant from getting to/from and/or riding the bus system?
☐ Yes ☐ No If yes, explain.

_____

_____

3. Is this person able to:

Give address and telephone number on request? ..... ☐ Yes ☐ No
Recognize streets and bus numbers? ..... ☐ Yes ☐ No
Sign his/her name? ..... ☐ Yes ☐ No
Deal with an unexpected situation? ..... ☐ Yes ☐ No
Ask for and understand directions? ..... ☐ Yes ☐ No
Be left alone on a transit vehicle? ..... ☐ Yes ☐ No

4. Is this condition:

Subject to significant improvement with treatment? ..... ☐ Yes ☐ No
Likely to become worse? ..... ☐ Yes ☐ No

5. Does applicant require a personal care attendant (Someone to travel with him/her)?
☐ Yes ☐ No

6. Is there any other effect of the condition which STS should be aware of? ..... ☐ Yes ☐ No

Please describe: _____

_____

_____

THIS CERTIFICATION HAS BEEN COMPLETED BY A LICENSED MEDICAL PROFESSIONAL

Licensed Medical Professional Information:

First Name Last Name Title (e.g. MD, NP, PA)

License/Certification number: _____

Which hospital/agency are you affiliated with? _____

Hospital/Agency name: _____

Address: _____

City:_____State:_____Zip: _____

Office phone #:_____Fax #: _____

I certify that the information contained in this application is true and correct to the best of my knowledge and ability. I hereby verify that the diagnosis of disability listed has been reviewed by me, is accurate and true, and represents the current physical and/or mental condition of the applicant named in this form.

Signature_____ Date:_____/_____/ _____