OFFICAL USE ONLY	
ADA ELIGIBLE □	TEMPORARY □
EXPIRATION: _____	

Oneonta Public Transit
104 Main St.
Oneonta, N.Y. 13820

PARATRANSIT APPLICATION

Oneonta Public Transit provides a demand response transportation service for those who are unable to use regular fixed route bus service and are ADA eligible. Before you can use this service you must:

1. Fill out part I of the form.
2. Have a certified health care professional who is familiar with your disabling condition complete part II, part III or part IV of this form. The part to be completed depends on whether the disabling condition in physical, visual, or mental.
3. Return the form to OPT (at address above). The health care professional may do this for you.

Oneonta Public Transit will evaluate the information on the form. You will be notified of OPT's determination within 21 calendar days of the request. If eligible, the applicant will receive an eligibility card good for two-years, as well as information on how to use the service.

OPT requires the information contained in this application in order to:

1. Determine whether you require specialized transportation.
2. Provide specialized service appropriate to your needs.
3. Be aware of any other special needs you may have.

All requested information will be kept confidential. It will not be released to any person, agency, organization or institution without your explicit permission. This information is being solicited solely for the purpose of establishing eligibility for the paratransit service which is designed to serve those individuals who are unable to use to OPT'S regular fixed route service.

If you require assistance with this form, please call: 432-7100.

PART I: TO BE COMPLETED BY APPLICANT

Questions 1-10 should be completed by the applicant. Please type or print clearly.

1. Name _____
2. Address _____
3. Telephone _____
4. Date of Birth _____

5. What is the disabling condition(s) which prevents you from using our regular fixed route service? _____
_____
_____

6. How does this condition(s) prevent you from using the regular fixed route service? Please explain completely. _____
_____
_____
_____
_____

7. Is there any other effect of the condition(s) which OPT should be aware?
_____
_____
_____

8. Do you use any of the following mobility aids? (Check all that apply)
   a. Wheelchair □
   b. Personal Assistant/Aide □
   c. Service Animal □
   d. Other mechanical aids: (Note: OPT is not equipped to transport "Geri Chairs.")
      Cane □ Crutches □ Walker □ Motorized Scooter □

9. I hereby certify that the information provided above is correct and I authorize the completion of the remainder of this application and the release of the application to OPT.

_____ _____
Signature Date

10. Name, address and telephone number of person completing this application, if other than the applicant.

_____
_____
_____ _____
Signature Date

PART II: TO BE COMPLETED FOR PERSONS WITH A PHYSICALLY DISABLING CONDITION

Questions 11-20 should be completed by a medical doctor or a physical or occupational therapist.

11. Medical diagnosis of disabling condition: _____
_____

12. Is this condition temporary? (Please check one) Yes □ No □
If yes, expected duration of condition: _____

13. Is this condition likely to become worse? (Please check one) Yes □ No □

14. Is this person able to walk without the assistance of another person? (Please check one)
    a. 200 feet? Yes □ No □ Only with great difficulty □
    b. ¼ mile? Yes □ No □ Only with great difficulty □

15. Is this person able to climb three 12" steps using a handrail? (Please check one)
    Yes □ No □ Only with great difficulty □

16. Is this person able to wait outside without support for 10 minutes? (Please check one)
    All of the time □ Some of the time □ Never □

17. Is this person able to ride in an automobile? (Please check one)
    All of the time □ Some of the time □ Never □

18. Does this person require the use of the following? (Check all that apply)
    a. Wheelchair: All of the time □ Some of the time □ Never □
    b. Cane, Crutches, or Walker: All of the time □ Some of the time □ Never □
    c. Prosthesis: All of the time □ Some of the time □ Never □
    d. Personal Assistant: All of the time □ Some of the time □ Never □

19. Are there any other effects of the condition of which OPT should be aware? Please describe. _____
_____

20. Name and signature of medical doctor or physical or occupational therapist completing this form.

Name and Title: _____

Agency Address: _____

Telephone: _____

_____ _____

Signature Date

PART III: TO BE COMPLETED FOR PERSONS WITH VISUAL IMPAIRMENT

Questions 21-27 should be completed by an ophthalmologist or optometrist.

21. Medical diagnosis of disabling condition: _____

_____

22. Is this condition temporary? (Please check one) Yes □ No □

If yes, expected duration of condition: _____

23. Is this condition likely to become worse? (Please check one) Yes □ No □

24. Visual Acuity: Right Eye _____/_____ Left Eye _____/_____

25. Visual Field:

Right Eye: Horizontal _____ Vertical _____

Left Eye: Horizontal _____ Vertical _____

26. Are there any other effects of the condition of which OPT should be aware? Please describe. _____

_____

27. Name and signature of Optometrist or Ophthalmologist completing this form.

Name and Title: _____

Agency Address: _____

Telephone: _____

_____ _____

Signature Date

PART IV: TO BE COMPLETED FOR PERSONS WITH A MENTALLY DISABLING CONDITION

Questions 28-34 should be completed by a medical doctor, psychiatrist or psychologist.

28. Medical diagnosis of disabling condition: _____
_____

29. How does this condition affect the individual's ability to use regular fixed route service?
_____
_____
_____
_____

30. Is this person able to:
    a. Give address and telephone number on request? Yes □ No □
    b. Recognize streets and bus numbers? Yes □ No □
    c. Sign his/her name? Yes □ No □
    d. Deal with an unexpected situation? Yes □ No □
    e. Ask for and understand directions? Yes □ No □

31. Is this condition:
    a. likely to improve with treatment? Yes □ No □
    b. likely to become worse? Yes □ No □

32. Should this person be accompanied while using OPT'S paratransit service?
    Yes □ No □

33. Are there any other effects of the condition of which OPT should be aware? Please describe. _____
_____

34. Name and signature of licensed psychologist, psychiatrist or medical doctor completing this form.
Name and Title: _____
Agency Address: _____
Telephone: _____
_____ _____
Signature Date

PLEASE RETURN COMPLETED APPLICATION BY MAIL TO:

Oneonta Public Transit
104 Main St.
Oneonta, N.Y. 13820

OR FAX COMPLETED APPLICATION TO: (607) 432-7482

BELOW THIS LINE IS FOR OFFICAL USE ONLY

APPROVED □ DENIED □

_____ _____

Signature Date