

To avoid Returning your application, you MUST send the following along with it:

- ✓ Copy of a Photo ID – Examples: License or State ID, Military ID, Passport **(Do not fax or email)**
- ✓ A list of your current medications

Please provide the following documents to assist in making a determination on your application:

- ✓ Certificate of Blindness, only **IF** it applies to you.
- ✓ A copy of an FSIQ (Full Scale Intelligence Quotient report), **OR** a Psychological Educational report **OR** a Neuropsychological report (only applicable **IF** you have an Intellectual/Learning/Cognitive disability. **Any of these 3 reports from any year is fine.**
- ✓ Current **IEP** report if still in school – (only applicable **IF** you have an Intellectual/Learning/Cognitive disability.
- ✓ Current **ISP** report if no longer in school – (only applicable **IF** you have an Intellectual/Learning/Cognitive disability.

**Massachusetts Americans with Disabilities
Paratransit Application Form**

Please note that any information given on this application will be kept confidential and shared only with professionals involved in providing the paratransit service on an as needed basis.

**THIS APPLICATION WILL BE ACCEPTED AT THE REGIONAL TRANSIT AUTHORITIES LISTED IN
ATTACHMENT A**

A. Personal Information				
Last Name:		First Name:		
Date of Birth:		Preferred Name:		
B. Current Residence				
Street Address (include building, apartment or room number information):				
City:		State:	Zip:	
Is this residence:				
☐	Single Family House		☐ Multifamily House	
☐	Apartment or Condominium Complex		Name:	
☐	Nursing or Assisted Living Facility		Name:	
☐	College or University		Name:	
Other:				
Is this a temporary residence: Yes No				
C. Mailing Address (if different from residence)				
Street Address (include building, apartment, or room number information): _____ (check here if same as above)				
City:		State:	Zip:	
D. Contact Information				
Primary Phone:		Alternate Phone:		
Email Address (optional):				
Preferred method of communication:				
☐ Phone	☐ Email	☐ Mail	☐ Text (if available at RTA)	
Preferred Language:				
E. Emergency Contact				
Last Name:		First Name:		
Relationship:		Agency (if Applicable):		
Primary Phone:		Alternate Phone:		

F. If someone assisted you in completing this form, please give the following information:				
Last Name:			First Name:	
Relationship:		Agency (if Applicable):		
Primary Phone:		Alternate Phone:		
May we contact this person with questions regarding your application? Yes No				
G. General Information About Your Disability				
Please indicate below if you need ADA service information in the following accessible formats:				
Large Print	Audio	Braille	Email	Other:
Are you certified for ADA Paratransit services by another service provider or transit agency: Yes No				
If yes:	Name of Service Provider:			State:
Please list the diagnosis' that prevent you from using the fixed route bus service: 				
Explain how your diagnosis prevents you from independently using the fixed route bus service:				
Is the disability or health related condition you describe:				
Permanent	If permanent is level of ability expected to change Yes No			
Temporary	If temporary how long is it expected to last:			
Unsure				
Does your health condition or disability change from day to day in a way that affects your ability to use the fixed route bus service? Yes No Sometimes				
If "Yes" or "Sometimes", Please explain:				
Are there times when someone accompanies you when you travel? Yes No Sometimes				

Do you use any of the following devices when you travel?		
Manual Wheelchair*	Powered Wheelchair*	Scooter*
Walker	Cane	Long White Cane
Oxygen	Communication Device	Crutches
Service Animal	Respirator	Other:
*The term wheelchair refers to any three or more wheeled device which is usable indoors. We will be able to accommodate a wheelchair if (1) the lift and vehicle can physically accommodate it and (2) if it is consistent with legitimate safety requirements. Legitimate safety requirements include but are not limited to such circumstances as a wheelchair of such size that it would block an aisle or would interfere with safe evacuation of passengers in an emergency, and/or is overweight when occupied for the vehicle specifications.		
H. Fixed Route Bus Service Experience		
Have you ever ridden the fixed route bus?		
Yes	How often and to what locations?	
	If not currently riding, why?	
Some providers have Travel Training, which is a free service that teaches people how to use the fixed route bus. If this is available in your area, would you be interested in receiving more information? Yes No		
I. Functional Ability		
Can you find your way to a public bus stop if someone shows you once?		
Yes	No	Sometimes
How far can you safely walk (using a mobility aid if necessary)? _____ Feet _____ Blocks		
Can you walk up/down a gradual hill?		
Yes	No	Sometimes
Can you see/detect curbs, ramps, and other drop off areas?		
Yes	No	Sometimes
How long can you stand and wait at a fixed route bus stop? _____ minutes		
Can you recognize and request stops when on the bus?		
Yes	No	Sometimes
Can you physically get on and off a fixed route bus? All RTA vehicles have lifts, ramps, or the ability to kneel and are accessible.		
Yes	No	Sometimes
If "No" or "Sometimes", please explain:		
Can you ask for, understand, and follow travel directions?		
Yes	No	Sometimes
If "No" or "Sometimes", please explain:		

J. Barriers		
What environmental barriers make it difficult for you to use the fixed route bus service?		
Lack of curb cuts/ramps	Steep hills	No sidewalks
Busy street I must cross	No crosswalk light/vocal indicator	Sidewalks in poor condition
Snow/Ice on Ground	Other (describe):	
Explain why the conditions you indicated make it difficult:		
K. Applicant Acknowledgement		
By signing below, you certify that the information submitted on this application is true to the best of your knowledge.		
Applicant Signature:		Date:
If an applicant cannot sign their name, the legal guardian must sign on their behalf:		
Legal Guardian Signature:		Date:

MEDICAL INFORMATION RELEASE AUTHORIZATION

For an RTA to evaluate your request they will need to contact a medical/clinical professional to confirm the information you provided. Please complete the following information and authorization form.

The following Licensed Health Care Professional is familiar with my disability and is authorized to provide the RTA with all information required to complete this certification.

Licensed Professional's Information		
Name:		Agency/Facility:
Mailing Address:		
City:	State:	Zip
Professional Certification:		
Physician	Nurse Practitioner	Physician Assistant
Psychiatrist	Licensed Social Worker	Neurologist
Occupational Therapist	Physical Therapist	Physician Assistant
Other:		
I hereby authorize the professional listed above to release any information necessary to determine Paratransit eligibility to the: <i>(Enter Name of RTA)</i>		
Applicant Signature:		Date:
Printed Name:		