OSU-STILLWATER COMMUNITY TRANSIT SYSTEM

PARATRANSIT ELIGIBILITY APPLICATION

Revised December 2019
The Bus, Stillwater’s public transportation system, provides fixed route service to all of the citizens of Stillwater. Every bus is equipped with a lift or ramp for those passengers that can not negotiate the steps on the buses. The Bus also offers a Paratransit service, which provides door-to-door service (as modified by FTA guidance for origin to destination for individuals who cannot use fixed-route service to make their trips). The Paratransit service area complements the fixed route system and utilized guidelines established to be eligible for this service, functional limitations of an individual’s disability must prevent use of a regular fixed-route service. Age, distance to a bus stop or inability to drive, by themselves, are not taken into consideration in determining eligibility. While your doctor’s verification of need is required for application, the final determination of eligibility will be made by the Paratransit ADA Certification.

Eligibility for use of Paratransit Services is determined by review of application and verification provided by Health Care Specialist.

Use of the OSU-Stillwater Community Paratransit service is based on the service area, which can be found online at
http://www.parking.okstate.edu/content/certification-process-0

Applicants for Paratransit service should complete Section I, Parts A through C. They should then provide their physician with Part D, to be completed by them and returned to applicant.

If you are able to use the fixed route bus system, but wish to apply for a disability card to receive reduced fares and priority seating, please complete the Disability card eligibility application in Part E.

Parts A through D, along with a photocopy of a picture ID, should be returned to:

OSU Student Disability Services Office
ADA Certification
1202 West Farm Road
SHC Room #155
Oklahoma State University
Stillwater, OK 74078
(405) 744-7116 (v/t)

The application must be filled out completely or it will not be processed!
Section I, Part A Contact Information
To be completed by, or for, the applicant

Last Name: ___________________________ First Name: ___________ Middle Initial: ___________

Home Address: ____________________________________________________________
(Street)
_________________________________________ Home Phone: (____)________
(City) (Zip)

Business Address: ____________________________________________________________
_________________________________________ Business Phone: (____)________
(City) (Zip)

Date of Birth: ___________________________ Sex: □ Male □ Female
(mm/dd/yyyy)

Emergency Contact _________________________ Phone Number ____________________

Do you use a Primary Care Attendant (PCA) ? Yes □ No □

Communication method: □ Speak independently □ Communication Device □ Sign Language □ Writing □ Other ________________

Aids: □ None □ Wheelchair □ Crutches □ Walker □ Power wheelchair
□ Scooter □ White Cane □ Service animal □ Oxygen tank □ Other ________________

Type of service expected to use: □ Fixed route (regular service) □ Paratransit

Does your disability require you to have assistance from the door of the bus to the door of your origin or destination? □ Yes □ No

Please provide names of others that can schedule trips on your behalf:
_______________________________________________________________________

Are you currently OSU Faculty/Staff/Student? □ Yes □ No

To be eligible provide the following for verification:
CWID: ___________________________
16 Digit number from your Valid OSU ID__________________________________________

(Copy PART A to Transit Office)
Section I, Part B Self Evaluation
To be completed by, or for, the applicant

Please answer the following questions. If you need help filling out the application, please call (405) 744-7116 (v/t) Monday thru Friday from 9:00 am until 5:00 pm for assistance. Your answers to these questions in this section will help us better understand your functional ability in specific areas.

1. Physician’s Name: __________________________________________________________

Physician’s Address: __________________________________________________________

(Street)                                                                                   

_______________________________________ Physician’s Phone: (   ) __________________

(City) (Zip)                                                                                   

2. Physician’s Name (if applicable): ________________________________________________

Physician’s Address: __________________________________________________________

(Street)                                                                                   

_______________________________________ Physician’s Phone: (   ) __________________

(City) (Zip)                                                                                   

Disability description: __________________________________________________________________

____________________________________________________________________________________

1. Please describe how your disability prevents you from using the regular OSU-
Stillwater fixed route bus system:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
2. Is your disability temporary  □ Yes  □ No

3. Do you currently use OSU-Stillwater fixed route bus service? □ Yes □ No

4. Have you had your disability for more than one year? □ Yes □ No

5. How far can you walk without assistance? (If you use a wheelchair or other mobility device, how far can you travel using that device?)

6. Does your disability change from day to day in a way that prevents you from using the regular buses?

□ YES, my condition is good on some days and bad on other days.

□ NO, my condition doesn’t change much from one day to another.

If you answered YES on question 6, answer the next two questions, otherwise, skip to question 7.

A. On a day when my condition is GOOD, (choose ONE):

   a. □ I can’t travel outside my house
   b. □ I can get to the curb in front of my house
   c. □ I can travel 1 block
   d. □ I can travel 2 blocks
   e. □ I can travel 4 blocks (1/4 mile)
   f. □ I can travel 6 blocks (1/2 mile)

B. On a day when my condition is BAD, (choose ONE):

   a. □ I can’t travel outside my house
   b. □ I can get to the curb in front of my house
   c. □ I can travel 1 block
   d. □ I can travel 2 blocks
   e. □ I can travel 4 blocks (1/4 mile)
   f. □ I can travel 6 blocks (1/2 mile)

7. Does the weather ever keep you from using fixed route bus service?

□ Yes (describe what kind and how this keeps you from using fixed route bus service) : ______________________________________________________

___________________________________________________________

□ No
8. If you use a manual wheelchair, please list your weight & the weight of the chair. Your weight ______________  Wheelchair weight ____________

9. If you use a Personal Care Assistant (PCA), check all that apply.
   The PCA helps me:
   □ get to the bus stop
   □ get on and off the bus
   □ while I ride the bus
   □ get where I am going once I am off the bus
   □ other: ________________________________

10. Which of the following limits your ability to use the fixed route buses? (check all that apply)

   □ physical disability
   □ visual impairment/blindness
   □ cognitive disability

   Please describe why this limits your ability to use the fixed route buses:
   ____________________________________________________________

11. How are your transportation needs being met now? Please check all that apply.

   □ walking
   □ personal transportation (car)
   □ public transportation (bus, taxi)
   □ agency-sponsored rides (who?) __________________________
   □ Paratransit service (who?) ____________________________
   □ ambulance (who?) _______________________________
   □ friend/relative
   □ other __________________________

   ____________________________________________________________
12. Most of the time can you:

- Cross the street, if there are curb cuts?
  - Always  □ Sometimes  □ Never  □ Not sure

- Cross a 2 lane street?
  - Always  □ Sometimes  □ Never  □ Not sure

- Cross a 4 lane highway with stop lights?
  - Always  □ Sometimes  □ Never  □ Not sure

- Go up and down hilly terrain
  - Always  □ Sometimes  □ Never  □ Not sure

- Tolerate temperature extremes (hot/cold)
  - Always  □ Sometimes  □ Never  □ Not sure

- Locate signs at night
  - Always  □ Sometimes  □ Never  □ Not sure

13. Are you able to perform the following functions without assistance?

- Find your way between familiar locations  □ Yes  □ No

- Signal a bus driver to get off at familiar stop  □ Yes  □ No

- Grasp coins, passes and handles  □ Yes  □ No

- Communicate addresses, destinations, and telephone numbers  □ Yes  □ No

- Ask for, understand, and follow directions  □ Yes  □ No

- Deal with unexpected situations or changes in routine  □ Yes  □ No

- Recognize a destination or landmark  □ Yes  □ No

14. Can you wait 10 to 15 minutes at a bus stop?

- □ Yes, always
- □ Yes, sometimes
- □ No, I can only wait _____ minutes
- □ I don’t know

15. Have you ever had training using a fixed route bus service?

- □ Yes  □ No

If yes, who trained you? ________________________________________
16. List three locations where you would like to have training on using the fixed route bus:

_____________________________________________________

_____________________________________________________

_____________________________________________________

17. Please list your most frequent trips and how you get there now

a. Origin: ______________________ Round trip? _________
   Destination? __________________ How often? _________
   Address: _______________________________________
   ____________________________________________
   ____________ (City) ____________ (Zip)
   □ by OSU-Stillwater Transit bus □ Other _____________

b. Origin: ______________________ Round trip? _________
   Destination? __________________ How often? _________
   Address: _______________________________________
   ____________________________________________
   ____________ (City) ____________ (Zip)
   □ by OSU-Stillwater Transit bus □ Other _____________
Section I, Part C Applicant Certification
To be completed by, or for, the applicant

I understand that the purpose of this application is to determine if I am eligible for ADA Paratransit services. OSU-Stillwater Community Transit or its contracted agents may need to talk to me or to see me at another time for an in-person interview and/or functional assessment to complete the application process. I understand that I must be truthful in answering the questions in this form and at my in-person assessment, if required. Giving false information is against the law and may result in loss of Paratransit service and/or criminal penalties. I agree to notify OSU-Stillwater Community Transit if I am no longer eligible for Paratransit service.

I authorize my physician, health care provider, trainer, specialist to discuss my diagnosis, treatment plan, medications, and/or prognosis for the purpose of determining my ability to use accessible OSU-Stillwater Community Transit buses.

I certify that the information in this application is true to the best of my knowledge. I understand if OSU-Stillwater Community Transit or its authorized agents receive information regarding change in my functional mobility, my eligibility status may be reviewed and changed. I understand that OSU-Stillwater Community Transit or one of its contracted agents will notify me of any change in my eligibility status and I may appeal such decision within sixty (60) days of notification.

__________________________________________
(Applicant’s Name, printed)

__________________________________________  ________________
(Applicant’s signature)                                     (Date)

☐ Copy of Applicant ID Card included

To be filled out if the applicant was helped by another person in completion of this application:

Name: ____________________________________________ Phone: ____________________

Address: ________________________________________________________________

______________________              __________________
(City)                   (Zip)

Relationship with applicant: ____________________________________________

__________________________________________  ________________
(Signature)                                     (Date)
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize ____________________________, my personal care attendant, to release and obtain information regarding my application/services for Paratransit.

Your records are protected under a number of federal and state confidentiality regulations and cannot be disclosed without your written consent unless otherwise provided for in state and federal regulations. You may revoke this consent in written request at any time except to the extent that action has been taken in reliance on it (e.g., information has been sent or received prior to your revocation, etc.)

You do not authorize further release to any other party. You further understand that Paratransit/OSU-Stillwater Community Transit System and its staff, employees, coordinators, and directors cannot be responsible for confidentiality of information disclosed after said information has been released pursuant to this authorization, and you hereby release Paratransit/OSU-Stillwater Community Transit System from any liability arising from such disclosure.

______________________________ ________________________________
Printed/Typed Name Witness

______________________________
Signature Date
The following Section (Part D) is to be filled out by a Health Care Professional. Failure to have this section completely filled out by the Health Care Professional will result in delay in processing of application.

Section I, Part D Professional Verification
to be filled out by Health Care Professional

Dear Health Care Professional:

You are being asked by ____________________ to provide information regarding their ability to use our transit system. Federal law requires that OSU-Stillwater Community Transit provide Paratransit services to persons who cannot use fixed-route transit services. The information you provide will allow us to evaluate this request and its application to specific trip requests. Certification to use this service will not be based solely on your verification in this document. Thank you for your cooperation in this matter.

To qualify for Paratransit services, a person must be unable to use regular public transit due to physical or cognitive disability. Individuals qualify if:
1. as the result of their disability, they cannot board, ride, or disembark a OSU-
Stillwater Community Transit fixed route bus (all fixed route buses are lift-equipped); or
2. they have a specific impairment-related condition which prevents them from getting
to/from a bus stop.

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

Resources for this program are limited and your evaluation of each person must be based
solely upon the individual’s ability to use regular transit. Your verification should consider
only presence of a disabling condition, not the applicant’s age or economic status. Please
exercise care in evaluating applicants for this program. Evaluation is based on federal
guidelines are used for establishing paratransit accessibility. The determination will be
applicable for use on any of the nation’s ADA compliant paratransit services.

CERTIFICATION PROCESS

1. Applicant has completed Parts A through C.
2. Health Care Professional completing Part D must be guided by criteria explained
herein.
3. OSU-Stillwater Community Transit or its authorized agents may contact the
certifying health care professional to verify accuracy of the information.
4. OSU-Stillwater Community Transit’s certification agent, the OSU Student Disability
Services Office, will make the final determination of the applicant’s eligibility.
5. The application must be filled out COMPLETELY for processing to occur.

OSU-Stillwater Community Transit is a limited special transportation service for disabled
persons who, because of cognitive or physical disability, find it IMPOSSIBLE to use regular
public transportation. All parts must be completely filled out by the authorized person who
signs below. Incomplete forms will be returned to the applicant.

A. Indicate nature of applicant’s disability (check as many as may apply):

☐ Non-ambulatory (uses wheelchair for mobility)
☐ Impaired or assisted ambulatory requiring special mobility aid __________
☐ Arthritis/Osteoarthritis (specify extremity) __________________________
☐ Amputation (specify extremity) _________________________________
☐ Cerebrovascular Accident
☐ Pulmonary Ills (does applicant require portable Oxygen Yes ☐ No ☐
☐ Neurological Impairment
☐ Cardiac Ills
☐ Kidney disease/dialysis
☐ Sight disability ☐ Legally blind ☐ Visually impaired ☐
☐ Incoordination
☐ Mental Retardation ☐ Moderate ☐ Severe ☐ Profound ☐
☐ Cerebral Palsy
☐ Autism
☐ Severe Muscle Spasms
☐ Seizures
☐ Loss of consciousness
☐ Mental illness (specify what it is about cognitive disability that limits use of regular bus service)

______________________________________________________________

______________________________________________________________

☐ Other ______________________________________________________

______________________________________________________________

Describe type and severity of disability in detail and how it prevents use of transit: __________________________________________________________

______________________________________________________________

B. The disability is: Permanent ☐ Temporary ☐
If temporary, expected duration is ______________________________

In your opinion, must this individual bring a competent attendant on each trip?
Yes ☐ No ☐

If applicant is visually impaired or blind, developmentally disabled, suffers from neurological impairment or is mentally limited, has applicant ability to receive training in fixed route buses? Yes ☐ No ☐

How far can the applicant walk unassisted? (If applicant uses a wheelchair or other mobility device, how far can the applicant travel using that device?):

☐ 1 block
☐ 2 blocks
☐ 4 blocks (1/4 mi)
☐ No limitation
* Other __________________________________________________________
Is there any other effect of the disability of which OSU-Stillwater Community Transit should be aware? Please provide an explanation. ________________

____________________________________________________________

____________________________________________________________

C. Is the applicant on any medication which might have an impact on ability to use public transportation □ Yes □ No Explain ________________

____________________________________________________________

____________________________________________________________

D. Your professional area of specialization is:

□ Family Physician  □ Cardiologist  □ Podiatrist  □ Optometrist  □ Audiologist
□ Psychologist  □ Physical Therapist  □ Rehabilitation Specialist  □ Independent Living Specialist
□ Registered Nurse/LPN  □ Other ________________

HEALTH CARE PROFESSIONAL CONTACT INFORMATION

Name: _____________________________________________

Title: ___________________ Agency/Company Name: __________________________

Professional License # (if applicable): _____________________________

Office Address: ______________________________________________________

____________________________________________________________

(Street)

(Street)

(City) (City) Office Phone Number: (____ ) _____________

(City) (City) (Zip) (Zip)
I hereby certify that the above information is true. The OSU Student Disability Services office will make the final determination on the applicant’s eligibility for OSU-Stillwater Community Paratransit service.

(Signature)  (Date)

THANK YOU FOR YOUR ASSISTANCE IN PROCESSING THIS APPLICATION!

Section II, Disability Certification Card Application
(Fixed Route Only)

Contact Information
To be completed by, or for, the applicant

Last Name:_________________  First Name:_____________  Middle Initial:__

Home Address:  _______________________________________________________
                  (Street)

                               (City)                                      (Zip)

Home Phone: ( )__________
Business Address: _____________________________________________

__________________         ______________
(City)                                   (Zip)

Business Phone: (____) __________

Date of Birth: ___________________ Sex: □ Male       □ Female
(dd/mm/yr)

Do you use a Primary Care Attendant (PCA)? Yes □       No □

Physician/Evaluator's Name:________________________________________

Physician/Evaluator's Address: _____________________________________

__________________      ______________
(Street)                                   (City)                                      (Zip)

Physician/Evaluator’s Phone: (____) __________

Disability description:_____________________________________________

______________________________________________________________

Communication method: □ Speak independently □ Communication Device □ Sign Language □ Writing □ Other ________________

Aids: □ None □ Wheelchair □ Crutches □ Walker □ Power wheelchair □ Scooter □ Cane □ Service animal □ Oxygen tank □ Other __________

______________________________________________________________

Are you currently OSU Faculty/Staff/Student?

□ Yes □ No
If yes please provide the following:

CWID:___________________;16 Digit Number from OSU ID
Used to verify Valid ID, must be updated if ID is replaced

Please attach documentation of your disability from a qualified professional. Acceptable forms of documentation include:

• Documentation from a physician regarding a medical or developmental disability.
- Report from a psychologist/diagnostician/psychiatrist regarding mental illness or learning disability.
- Audiologist report regarding deafness or hearing impairment.
- Ophthalmologist report regarding visual impairment.

Mail completed application to:

OSU Student Disability Services Office
ADA Certification
315 Student Union
Oklahoma State University
Stillwater, OK 74078