Thank you for inquiring about eligibility for ADA Paratransit Service. Concord Kannapolis Rider Transit’s Paratransit Service is a “Safety Net” for people with physical, cognitive or visual disabilities that are functionally unable to independently use the CK Rider fixed route service either all of the time, temporarily or only under certain circumstances. Enclosed are the ADA Paratransit Application and Eligibility Brochure that explains ADA Paratransit Service. Please read the Eligibility Brochure carefully before completing your application.

The Steps in the Eligibility Process

1. Request the application packet.
2. Read the Eligibility Brochure that is enclosed.
3. Complete all questions on the Paratransit Application that follows this page.
4. Submit your application to your physician, or other professional, to complete the professional verification section.
5. Mail your signed and completed application and professional verification form to:

Concord Kannapolis Area Transit (Rider) Paratransit Services
3600 South Ridge Avenue
Concord, NC 28025

6. You will be asked to attend/participate with an in-person interview and functional assessment. Your eligibility will be determined within 21 days from the date you complete your in-person interview and functional assessment. You will be notified by letter as to your eligibility status.

7. If you do not receive written notice of Rider Transit's decision within 21 days, you may request paratransit services until a decision has been made by calling (704)920-5876 or TDD (800) 735-2962.

An incomplete application will be returned and will delay processing.

EVERY QUESTION MUST BE ANSWERED AND LEGIBLE.
Application for ADA Paratransit Eligibility

Please complete ALL sections of this form. An incomplete application will be returned. The information you provide will help determine what type of transportation service is the right service for you. All information will remain confidential.

APPLICANT INFORMATION (PLEASE PRINT)

First Name___________________   Middle Initial___   Last Name___________________
Mailing Address________________________________ Apt#_______
City_____________________   State_______   Zip__________ County_____________
Home Address __________________________________________________________
(If different from mailing address)
Name of Facility/Apartment Building________________________________ Gate Code:_____ 
(City_____________________   State_______   Zip__________   County_____________
Phone (daytime) ______________________   (evening) _______________________
Cellular #______________________    TTY for hearing impaired___________________
Email address ____________________________  (If applicable)
Date of Birth _____/_____/_______   Sex:    Male    Female

New Application or Recertification (ID# ________________)

Please send me written information in an alternate format.

Large Print   Audio Tape   Braille   CD Other: ______________  Español

Please provide the name of a LOCAL relative/friend in case of an emergency:
Name_________________________________    Relationship____________________
Phone (daytime) ________________________     (evening) ____________________

FOR STAFF USE ONLY

Date Received __________________________________ Initials _________ Date
Returned __________________________________ Initials _________
Application Date Complete/Distributed ___________________________ Initials _________
How do you travel now? Please check all that apply to you.

Walk  drive a car  ride in someone’s car  taxi  bicycle  
Paratransit  Rider Transit Fixed-Bus  Other:___________________

List your common trips and the places you most often travel to in the spaces indicated below.

A. Trip destination:

Building Location / Name ________________________________________________

________________________________________________________________________________
Number and Street                             City                               ZIP Code

B. Trip destination:

Building Location / Name ________________________________________________

________________________________________________________________________________
Number and Street                             City                               ZIP Code

C. Trip destination:

Building Location / Name ________________________________________________

________________________________________________________________________________
Number and Street                             City                               ZIP Code
Do you have a cognitive or physical disability that, some or all of the time, causes you to be unable to get on, ride or get off the fixed-route buses by yourself, without the help of another person?  
Yes (If yes, explain)  No:

What types of disabilities cause you to be unable to use Rider Transit's Buses?
physical disability  visual impairment/blindness  developmental disability
mental illness  recent surgery  other __________________

When was your disability diagnosed?  __________________
Month/Year

Is your disability considered Stable?  Yes  No

Is your disability considered Progressive?  Yes  No

Is your disability temporary?
Yes, I expect it to last _______ months.  No, it is permanent  I don’t know.

Paratransit Operators are unable to perform the duties of a Personal Care Attendant (PCA). Will you need to travel with a PCA or someone to assist you when you use paratransit?
Yes; sometimes  Yes; always  No

If always or sometimes, how does a PCA or other person assist you?

Can you wait for a regular Rider Transit bus?
Yes  Only if there is a bench or shelter;  No  more than 15 minutes;  No

Can you maintain balance while seated on a moving vehicle?
Yes  No

How far can you walk on level ground?
Less than 1 block  1 block  2 blocks  3 or more blocks

How far can you go on level ground with your mobility aid, if you use any?
Less than 1 block  1 block  2 blocks  3 or more blocks
If you use a power wheelchair, or scooter, Rider Transit will need to verify what you and your wheelchair weigh together. Many power wheelchairs and scooters are very heavy. (RT paratransit vehicle lifts are designed to lift 600 to 800 pounds, depending on the paratransit vehicle type.)

Which of these mobility aids do you currently use when traveling? Please check all that apply to you. Do not select a device that you are waiting on for approval or prescription.

- white cane
- powered wheelchair *
- powered scooter/cart *
- support cane
- manual wheelchair *
- crutches
- power assist wheelchair
- leg brace
- prosthesis
- service animal
- portable oxygen
- communication board
- no mobility aid
- other (please specify) __________________________________________

* “Wheelchair” means a three or more wheeled mobility device.

If you checked manual wheelchair, power wheelchair, or powered scooter/cart, please provide the following information:

Is your mobility device oversized?   Yes    No

Does your mobility device weigh more than 600 pounds when occupied?   Yes    No

Do you know how much you and your wheelchair weigh together?   Yes    No

If yes, please provide the total weight: ___________________ lbs.

What is the make/model of your wheelchair or scooter?

Make _______________________ Model ________________________________

What is the width of your wheelchair or scooter? ________ inches (if available) What is the length

of your wheelchair or scooter? ________ inches (if available)
CURRENT USE OF Rider Transit’s FIXED-ROUTE BUSES

Do you use Rider Transit’s fixed-route buses by yourself?  Yes  No

If yes, how often?_________________ Which routes do you use?_________________

When was the last time you used Rider Transit’s fixed-route by yourself? _______________

Do you need someone to travel with you when you travel in the community or when you use the accessible fixed-route buses?

Yes; sometimes  Yes; always  No

Have you ever had training on how to travel around the community or how to use Rider Transit’s accessible fixed-route buses?

Yes  No  Never ridden bus

FUNCTIONAL ABILITIES: USING FIXED-ROUTE BUSES

What best describes your functional ability to use the fixed-route buses on your own? (CHECK ALL THAT APPLY)

I can get to and from bus stops that are not too far.
The severity of 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 have a disability or health condition which causes me to be unable to ride the fixed-route buses when weather is extremely hot.
I have a disability or health condition which causes me to be unable to ride the fixed-route buses when weather is extremely cold.
I am unable to travel on the fixed-route buses when there is rain and wind due to my disability or health condition.
I can get to and from bus stops only if there are curb-cuts and level sidewalks.
I have difficulty understanding or remembering all the things I would have to do to use the fixed-route buses.
I can use the fixed route buses if it is someplace I go all the time.
I am unable to travel on the fixed-route buses during periods of darkness due to my disability or health condition.
I can never use the fixed-route buses by myself.
I am not able to use the fixed-route buses by myself for other reasons: Please explain:
CERTIFICATION OF APPLICANT

I understand the information I provided on this application is true and correct to the best of my knowledge. The purpose of this application is to determine if I am eligible to use Paratransit services, or if at times I can ride the Concord Kannapolis Rider Transit fixed-route buses. I understand that falsification of information could result in a loss of Paratransit services as well as a penalty under the law.

I also understand that, at no expense to me the Concord Kannapolis Area Rider Transit may require that I participate in an in-person functional evaluation of my travel skills and agree to such a functional evaluation if one is necessary.

I agree to notify Concord Kannapolis Rider Transit if my condition changes, if my mobility device has been replaced, if I have a new mobility device, or if I no longer need to use Paratransit service.

___________________________________________________  Date_________________
(Signature of Applicant or Guardian if Applicable)

Person Completing Application If Not the Applicant:

Printed Name______________________  Relationship to Applicant_______________

Signature_____________________________________  Date___________________

Daytime Phone #__________________  Evening Phone #__________________

This concludes the applicant’s portion of the application. The following page MUST be completed by a Professional.

DO NOT SEPARATE THE APPLICATION FROM THE PROFESSIONAL VERIFICATION.

BOTH SECTIONS MUST BE MAILED TOGETHER.
PROFESSIONAL VERIFICATION (REQUIRED)

To The Applicant - Please have this page completed by a professional before mailing your application to Rider Transit. Any one of the professionals listed below may sign the application. If this page is not completed and signed by one of the professionals listed below, the application will be returned to you and processing will be delayed.

MUST BE COMPLETED BY A PROFESSIONAL, NOT THE APPLICANT

To the Professional - Please check your professional title:

- Physician
- Physician’s Assistant
- Registered Nurse
- Nurse Practitioner
- Psychiatrist
- Psychologist
- Case/Resource Manager
- Chiropractor
- Physical Therapist
- Occupational Therapist
- Certified Orientation & Mobility Specialist

Please describe the medical diagnosis, physical or cognitive disability which causes the applicant to be unable to independently use a lift-equipped bus some or all of the time. Must provide specific details or application will be returned:

The ADA regulations state that persons are eligible for paratransit service if, because of a disability or medical condition, they are physically or cognitively unable to (not discomforted by or find difficult) independently use lift-equipped public transit service. ADA paratransit eligibility is not based on the person’s lack of knowledge of bus service, distance from bus service, ability to drive, language ability, or age. The information you provide will assist in determining under what circumstances this applicant may be eligible for paratransit service.

Name of Applicant: _____________________________ DOB _____________

Is this condition temporary?  
- No  
- Yes; for:  4 mos  6 mos  9 mos  12 mos

This person is is not able to self-supervise daily activities

Last date of face-to-face contact with this applicant was _____/_____/______

I certify under penalty of perjury under the laws of the State of North Carolina that the information contained in this application is true and correct.

Signature_________________________________________ Date _____/_____/______

*Printed Name________________________________ Phone________________

Clinic/Agency____________________ Address________________________

City ____________________________ State _____ ZIP ________________

Professional License/Registration/Certification#____________ State_____

*This form expires 90 days from the signature date.

- Form does not need to be typed -
PROFESSIONAL VERIFICATION (REQUIRED)

To The Applicant - Please have this page completed by a professional before mailing your application to Rider Transit. Any one of the professionals listed below may sign the application. If this page is not completed and signed by one of the professionals listed below, the application will be returned to you and processing will be delayed.

MUST BE COMPLETED BY A PROFESSIONAL, NOT THE APPLICANT

To the Professional - Please check your professional title:

physician  physician's assistant  registered nurse/nurse practitioner  psychiatrist  psychologist
case/resource manager  chiropractor  physical therapist  occupational therapist  certified
orientation & mobility specialist

The ADA regulations state that persons are eligible for paratransit service if, because of a disability or medical condition, they are physically or cognitively unable to (not discomforted by or find difficult) independently use lift-equipped public transit service. ADA paratransit eligibility is not based on the person’s lack of knowledge of bus service, distance from bus service, ability to drive, language ability, or age. The information you provide will assist in determining under what circumstances this applicant may be eligible for paratransit service.

Name of Applicant: ___________________________  ___________________________

Please describe the medical diagnosis, physical or cognitive disability which causes the applicant to be unable to independently use a lift-equipped bus or light rail train some, or all of the time. Must provide specific details or application will be returned:

Patient seen by me one time on 3/31/13, 78 years old with below the knee amputation, LLE gangrene, OA spine / neuropathy / RLE Edema / Severe difficulty with ambulation

Is this condition temporary?  No       Yes; for:  4 mos  6 mos  9 mos  12 mos

This person is           is not able to self-supervise daily activities

Last date of face-to-face contact with this applicant was 03 / 31 / 13

I certify under penalty of perjury under the laws of the State of California that the information contained in this application is true and correct.

Signature ___________________________  Date 04 / 10 / 13 *

Printed Name ___________________________  Phone 704-920-5876

ABC Clinic  Address

_________________________  ZIP 28025

Professional License/Registration/Certification# A77777  State NC

Clinic/Agency

City ___________________________

* This form expires 90 days from the signature date.