APPLICATION FOR CERTIFICATION OF AMERICANS WITH DISABILITIES ACT (ADA) PARATRANSIT ELIGIBILITY

If you are an individual with a disability and believe you are unable to use the Central Midlands Transit (The COMET) fixed route public transit system (buses that follow set schedules and stops) some or all of the time, you may be eligible for ADA Paratransit Service on the Dial-a-Ride Transit System (DART) some or all of the time. The information obtained in this application will assist The COMET with understanding your abilities, travel changes and barriers in the environment that may prevent you from using the fixed route system. **All information contained in this application will be kept confidential and only be shared with professionals involved in the evaluation process. Complimentary transportation will be provided to applicants for functional assessments.**

It is important that **ALL SECTIONS** of this application be completed. **If your application is not complete when received by The COMET, it will be returned to you** and that will delay having your application processed.
If you have any questions or need assistance with completing this application, please call (803) 255-7123. **Please mail completed application to:**

Able South Carolina
Attn: Paratransit Eligibility
720 Gracern Road, Ste. 106
Columbia, South Carolina 29210

Email: transportation@able-sc.org

THE COMET'S ADA PARATRANSIT ELIGIBILITY PROCESS INCLUDES:

1. Application will be reviewed to ensure all information is completed including professional verification of disability.

2. A phone and/or in-person functional assessment of transit related abilities will be scheduled 3 – 12 days after receipt for your application.

3. A written eligibility determination will be made within 21 days of receipt of a COMPLETED application. If you are denied eligibility, you have a right to appeal. Information on the appeals process will be sent to you when you are notified of the eligibility denial. If you have not heard from The COMET after 21 days, you will be granted Presumptive Eligibility (temporary eligibility that will allow you to use DART until a final determination has been made).

APPLICATION INFORMATION
(Please Print or Type)

First Name: ______________________ **Date of Birth:** __________

Last Name: _____________________ **Middle Initial:** __________

Residential Address:____

City: _________________ **State:** ________**Zip Code:** ____________

Daytime Phone: (   ) _________ **Evening Phone:** (   ) _________

TDD/TTY Number: (   )____

Email Address: ____

Sex: M / F (circle one)

Emergency Contact Name: _____________________________________

Daytime Phone: (   ) ___________________

Evening Phone: (   ) ___________________

Mailing Address: (if different from above)

____

City: ________________ **State:** _______ **Zip Code:** ___________

Would you like further written information provided to you in accessible format? Yes____ No____ If YES: Please indicate your preferred format:

Large Print: _________ **Braille:** _________ **E-Text:** __________

Other: ______________

DISABILITY & MOBILITY EQUIPMENT

1. Which of the following limit your ability to use The COMET's fixed route bus service? (Check all that applies)

☐ Physical disability ☐ Low Vision/blindness

☐ Developmental disability ☐ Psychiatric disability

☐ Intellectual disability ☐ Other

2. Please describe your disability (or disabilities) in more detail:

____
____
____
____
____
____

3. How does the above disability/disabilities prevent you from using the COMET's fixed route bus service?

____
____
____

4. Which of these mobility aids or equipment do you use to help you get where you need to go? (Please check all that apply)

☐ None ☐ Communication device ☐ Cane
☐ Walker ☐ Powered Scooter/cart ☐ Power Wheelchair
☐ Crutches ☐ Manual Wheelchair ☐ White Cane
☐ Hearing Aid ☐ Service Animal ☐ Portable Oxygen
☐ Other ___________________

5. If you use a wheelchair or scooter, is it:

30 inches wide or less? ☐ Yes ☐ No
48 inches long or less? ☐ Yes ☐ No
600 pounds or less when occupied? ☐ Yes ☐ No

6. Can you wait outside for fifteen minutes?
☐ Yes ☐ No ☐ sometimes

YOUR TRANSPORTATION NEEDS

1. **Do you require a Personal Care Attendant (PCA) when you travel?**
   ☐ Yes ☐ No ☐ Sometimes

2. **Please check here if you would be interested in participating in travel training so that you can learn to use The COMET's fixed route bus services. After travel training, you may qualify for reduced fares on The COMET's fixed route bus service.**

   ☐ Yes ☐ No

3. **Please list your 5 most frequent trip destinations, purposes, and how you get there now.**

Destination Address	Purpose	How do you get there now?
____________________	____________	____________________
____________________	____________	____________________
____________________	____________	____________________
____________________	____________	____________________
____________________	____________	____________________

4. **I can cross streets independently under the following conditions:** (check all that apply)
   a. At quiet streets with very little traffic
      ☐ Usually ☐ Sometimes ☐Never

   b. At most traffic lights
      ☐ Usually ☐ Sometimes ☐Never

   c. Anywhere
      ☐ Usually ☐ Sometimes ☐Never

   d. Never
      ☐ Usually ☐ Sometimes ☐Never

APPLICANT CERTIFICATION/SIGNATURE

Please complete this section **UNLESS** you are a minor or have a legal guardian. If you are a minor or have a legal guardian, your parent or guardian must complete section B.

SECTION A

a.) I certify that the information provided in this application is accurate.

b.) I understand that I must complete a functional assessment of my abilities.

c.) I understand that the purpose of this application is to determine if there are times that I cannot use fixed route services and am eligible to use The COMET's paratransit services, DART.

d.) I understand all information will be kept confidential and only the information required to provide the services I request will be disclosed to those who perform those services.

e.) I understand that the professional references provided will be contacted to verify all information included on this application.

f.) I further certify that I understand that The COMET reserves the right to periodically re-evaluate my eligibility for use of the Dial-A-Ride-Transit (DART) service.

g.) The professionals listed below are authorized to provide information to The COMET or its representatives as may be required to complete this service eligibility review/certification process.

Signature of Applicant: ____________________ **Date:**____________

Signature of Witness: _____________________ **Date:**____________

SECTION B (for parents and legal guardians)

a.) I certify that the information provided in this application is accurate and I understand that the applicant must complete a functional assessment of his or her abilities.

b.) I understand that the purpose of this application is to determine if there are times that the applicant cannot use fixed route services and is eligible to use The COMET's paratransit services, DART.

c.) I consent to the Applicant's interview and functional assessment of his or her travel abilities and limitations to determine ADA Paratransit service eligibility.

d.) I understand that the Applicant must be present for the interview and functional assessment.

e.) I understand that I may be present with the Applicant during the interview and any functional assessment, and state that:

❒I will be present,

❒I designate ______________________________to be present on my behalf, or

❒I waive my right to be present and do not designate another person to be present on my behalf.

Signature: __________________________________**Date:** ____________

Name Printed: ____

Relationship to applicant:_______________________________________

PERSON COMPLETING THIS FORM IF OTHER THAN APPLICANT

☐ I certify that the information provided in this application is true and correct based upon information given to me by the applicant.

☐ I certify that the information in this application is true and correct based upon my knowledge of the applicant's health condition or disability.

Full Name: __________________________**Daytime Phone:** (   ) __________

Address: ____

City: _____________________________**State**: _______ **Zip**:_______________

Relationship to Applicant: ____

Signature: __________________________________ **Date:**_______________

INFORMATION-REQUIREMENT FOR ALL APPLICANTS

Please list the names of two (2) professionals, who will be contacted for verification of the information provided. Acceptable professionals include: Licensed Physicians; Licensed Physical Therapists; Certified Rehabilitation Specialists; Licensed Optometrists/Ophthalmologists; Certified Audiologists; Certified Psychologists; Nurses (LPN or RN); Registered Occupational Therapists; Certified Speech Pathologists; and Licensed Social Workers.

Name: ______________________________	Name: ______________________________
Phone: ______________________________	Phone: ______________________________
Professional Title: ______________________________	Professional Title: ______________________________
Address:_____________________	Address:_____________________
City:__________________________	City:__________________________
State:_____________ Zip:______	State: _____________ Zip:___________

Section B Professionals complete Sections B-F as appropriate.

The ADA Paratransit Service known as Dial-a-Ride-Transit (DART) provides curb-to-curb, paratransit services to persons who cannot use Fixed Route System. The information you provide will allow us to make an appropriate evaluation of this request for certification. Thank you for your cooperation.

B1 Capacity in which you know applicant.

____

B2 What is the health condition or disability that prevents the applicant from using the regular fixed-route service? (Please list all applicable conditions/disabilities)

____

____

B3 Is the disability temporary ☐ yes ☐No

Section C If the applicant has a visual impairment

C1 Visual Acuity with Best Correction
Right Eye______ Left Eye ______ Both _____

C2 Visual Fields
Right Eye______ Left Eye ______ Both _____

Section D If the applicant has a disability affecting mobility, is the applicant able to:

D1 Wait outside without support for 10 minutes.
☐ Yes ☐ No ☐ Sometimes

D2 With the use of a mobility aid or on his or her own, how far will the applicant be able to travel without the assistance of another person?
☐ Less than 200 feet ☐ 1/4 mile (3 blocks)
☐ 1/2 mile (9 blocks) ☐ more than ¾ miles

D3 Is the applicant's ability to independently travel the distance affected by: (check all that apply)
☐ Hot weather ☐ Cold weather ☐ Steep Hills ☐ Street Crossings

Section E If the applicant has a cognitive disability, is the applicant able to:

E1 Give Address/telephone numbers upon request? ☐ Yes ☐ No

E2 Recognize a destination landmark? ☐ Yes ☐ No

E3 Deal calmly with unexpected situation/changes in routine? ☐ Yes ☐ No

E4 Ask for, understand and follow directions? ☐ Yes ☐ No

E5 Safely and effectively travel through crowded facilities? ☐ Yes ☐ No

Section F

Professional's Name (print):

____

Professional's Mailing Address:

____

City: ______________________ **State**: _____________ **Zip**: ______________

Office Phone: _____________________ **Fax:** _________________________

Professional Signature:

____