



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 will delay your application being processed.

If you have any questions or need assistance with completing this application, please call (803) 255-7123. It is also very important to mail the application to the address listed below.

DO NOT MAIL THIS APPLICATION TO THE COMET. IT WILL DELAY YOUR PROCESSING TIME.

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)**

<input type="checkbox"/> This is my first time applying for DART
<input type="checkbox"/> I am recertifying for DART

Last Name: _____ **Middle Initial:** _____ **First Name:** _____

Date of Birth: _____ **Sex:** M / F (circle one)

Residential Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Daytime Phone: () _____ **Evening Phone:** () _____

TDD/TTY Number: () _____

Email Address: _____

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)

- | | |
|---|---|
| <input type="checkbox"/> Physical disability | <input type="checkbox"/> Low Vision/blindness |
| <input type="checkbox"/> Developmental disability | <input type="checkbox"/> Psychiatric disability |
| <input type="checkbox"/> Intellectual disability | <input type="checkbox"/> 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)

- | | | |
|--------------------------------------|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Communication device | <input type="checkbox"/> Cane |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Powered Scooter/cart | <input type="checkbox"/> Power Wheelchair |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> White Cane |
| <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Service Animal | <input type="checkbox"/> Portable Oxygen |
| <input type="checkbox"/> Other _____ | | |

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

- | | | |
|-----------------------------------|------------------------------|-----------------------------|
| 30 inches wide or less? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 48 inches long or less? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 600 pounds or less when occupied? | <input type="checkbox"/> Yes | <input type="checkbox"/> 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.

<u>Destination Address</u>	<u>Purpose</u>	<u>How do you get there now?</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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: _____ Phone: _____	Name: _____ Phone: _____
Professional Title: _____	Professional Title: _____
Address: _____	Address: _____
City: _____	City: _____
State: _____ Zip: _____	State: _____ Zip: _____

Thank you for applying to DART. Just a reminder to mail your completed application to:

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