

Oshkosh Transit System's

Application Form for ADA Paratransit Services

<i>For office use only:</i>	
Applicant's Last Name	_____
Date Received	____ / ____ / ____
Date Processed	____ / ____ / ____
Status (Approved or Denied)	_____
Expiration Date of Card	____ / ____ / ____
Circle One:	
	unconditional – conditional – temporary
Notes	_____

Introduction:

The **Americans with Disabilities Act (ADA)** of 1990 requires Oshkosh Transit System (OTS) to provide paratransit service to persons with disabilities who cannot access the fixed-route bus system due to their disability. Please complete this application if you have a disability that prevents you from using the city bus system. Applicants must reside in the City of Oshkosh to qualify.

Application Instructions:

The applicant or applicant's legal guardian needs to ensure all sections of the form are completed. This includes the following sections: Applicant Information, About Your Disability, About Your Mobility, Release of Information, and Request for Professional Verification. If necessary, use the back side each page to continue answers. The Request for Professional Verification section will need to be completed by a licensed professional familiar with the applicant's disability. Please keep the entire application intact for the professional verification. Incomplete applications will not be processed and will be returned to the applicant. If you have any questions about the application, please call OTS at 232-5341.

Please return completed application to:

American Red Cross, 515 S. Washburn, Suite 201, Oshkosh, WI 54904

Application Review Process:

The Red Cross receives and processes ADA paratransit applications on the behalf of OTS. In addition to the initial application review, it may be necessary for OTS to contact professionals listed in the application; conduct an in-person assessment; and/or schedule an appointment with occupational health to determine if the applicant is eligible. An eligibility determination will be made within 21 days of receipt of a completed application. The review process is suspended if there is no response to requests for additional information from the applicant or professionals/contacts listed by the applicant.

Applicants that qualify for the service will be mailed an ID card, service policies, and instructions on how to use the program. If the application is denied, the decision can be appealed. A description of the appeals process will be included with the denial letter to the applicant.

The application process is an ADA requirement and designed to strictly limit eligibility according to the regulatory criteria defined in the ADA. Individuals that are able use the city bus for all trips during city bus hours are not eligible for ADA paratransit service. This ensures the best possible service for individuals that do qualify for and rely on paratransit. Existing paratransit users that must reapply for paratransit service are not guaranteed continued eligibility based on a previous certification.

Additional Paratransit Programs:

OTS also offers additional non-ADA paratransit programs tailored to help seniors, low-income workers, and rural Winnebago County residents. For more information about OTS's other paratransit programs, please call 232-5340 or visit www.oshkoshtransit.com .

REQUIRED INFORMATION FOR CERTIFICATION OF ADA ELIGIBILITY

Please type or print clearly. Incomplete applications will be returned.

Applicant Information

Last name _____ First name _____ M.I. _____

Current address _____ Apt. #: _____

Name of residence facility (if applicable) _____

City _____ State _____ Zip _____

Date of birth ____ / ____ / ____ Gender: Female Male

Telephone numbers (home) _____ (cell) _____

1. Are you eligible for rides under Title 19 (XIX), also known as MA rides provided under Medicaid (rides to/from medical appointments)? Not to be confused with Medicare.

Yes **No**

2. If you are a member/participant of the following programs, please check one.

Lakeland Care District (Family Care) **IRIS** **Neither**

About Your Disability

1. What is your disability or medical condition that prevents you from using the city bus?

2. Explain how your disability prevents you from independently using the city bus. Be specific: _____

3. Is the condition you describe temporary? **Yes** **No**

If "**Yes**," the expected duration is until: ____ / ____ / ____

4. Is your condition affected by weather, temperature, and/or environmental conditions?

Yes **No**

If "**Yes**," please explain. _____

Did you know that all city buses are accessible? All OTS city buses have wheelchair ramps and kneelers (lowers bus near curb level) for ease in boarding. Bus drivers also make key location announcements.

About Your Disability cont.

5. Are there any other effects of your disability or health condition of which we should be aware? _____

About Your Mobility

1. Do you use any of the following mobility aids or specialized equipment while traveling? Check all that apply.
- | | | |
|--|---|---|
| <input type="checkbox"/> Cane | <input type="checkbox"/> Service Animal | <input type="checkbox"/> Communication Board |
| <input type="checkbox"/> White Cane | <input type="checkbox"/> Power Wheelchair | <input type="checkbox"/> Oxygen Tank |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Power Scooter (3-Wheeler) | <input type="checkbox"/> Other Aid _____ |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Manual Wheelchair | |
| <input type="checkbox"/> Augmentative Communication Device | | |
| <input type="checkbox"/> I do not require any assistive devices | | |

2. If you use a wheelchair or scooter while traveling, what are the specifications?
 Wheelchair/scooter **Make** _____ **Model** _____
 How wide is it*? _____ **inches** How long is it*? _____ **inches**
*measured 2 inches above the ground
 How heavy is it when occupied (total weight of chair and person)? _____ **pounds**

The ADA defines a "common wheelchair" as no more than 30 inches wide, 48 inches long, and 600 pounds when occupied. If your mobility device exceeds these dimensions, the ADA does not guarantee paratransit service.

3. With the use of a mobility aid (if used), how far can you travel independently without assistance on another person?
- | | | |
|--|---|---|
| <input type="checkbox"/> Less than 100 feet | <input type="checkbox"/> Only 1 block | <input type="checkbox"/> ¼ mile (3 blocks) |
| <input type="checkbox"/> ½ mile (6 blocks) | <input type="checkbox"/> ¾ mile (9 blocks) | <input type="checkbox"/> more than ¾ mile (>9 blocks) |
4. How far from your home is the nearest city bus stop?
- | | | |
|---|--|--|
| <input type="checkbox"/> Less than 1 block | <input type="checkbox"/> 1-2 blocks | <input type="checkbox"/> 3-4 blocks |
| <input type="checkbox"/> 5 or more blocks | <input type="checkbox"/> I don't know | |
5. Can you wait outside without support for 10 minutes?
 Yes **No** **Sometimes**

If "**Sometimes**," explain: _____

About Your Mobility cont.

6. Have you ever ridden the city bus in Oshkosh on your own? Yes No

If "Yes," list the trips when you are able to use the city bus. _____

If "No," describe why you have not used the city bus for any trips. _____

7. If personalized travel training was provided to teach you how to ride the city bus, would you be willing to participate? Yes No

If you are able to ride the city bus for some or all trips, but need training, feel free to contact Oshkosh Transit System at (920) 232-5340 or email transit@ci.oshkosh.wi.us . We can provide travel training assistance to anyone that is able to use the bus.

Release of Information

1. So OTS can verify the information you provided, please list the name(s) of at least one professional, which may include a physician, agency representative or other professional familiar with your disability.

Professional's name _____ Title _____
Facility _____ Telephone # _____
Address _____
City _____ State _____ Zip _____

Professional's name _____ Title _____
Facility _____ Telephone # _____
Address _____
City _____ State _____ Zip _____

I, the applicant, understand that the purpose of this application form is to determine my eligibility to use OTS paratransit services. I hereby authorize the above professional(s) to provide the required information to OTS. I certify that all of the information here and on the preceding pages is complete and true. I agree to release the information requested to OTS and any eligibility review panel. I understand that the information contained herein will be treated as confidential and will not be shared with any other person or company unless authorized or legally required. I understand further that OTS reserves the right to request additional information at its discretion.

Signature of applicant _____ Date ____ / ____ / ____

Printed name of applicant _____ Date ____ / ____ / ____

Printed name of preparer (if applicable) _____

If preparer represents an agency, please print the agency info here:

Agency name _____ Phone # _____

Signature of parent or legal guardian _____ Date ____ / ____ / ____

REQUEST FOR PROFESSIONAL VERIFICATION

Please keep the entire application attached to this form.

All information requested below must be completed by a licensed professional.

The individual who has asked you to review this application and complete the form below is applying to Oshkosh Transit System (OTS) to be considered eligible for Americans with Disabilities Act (ADA) paratransit service. ADA paratransit service is intended ONLY for those trips that the person cannot take on the regular public bus system due to his/her disability.

Eligibility is strictly limited to individuals with disabilities that meet regulatory criteria defined in the ADA. The information requested in this application will allow OTS to make an appropriate determination of the applicant's eligibility for this service. It is important to fully complete this form to avoid delay in the evaluation process. Thank you for your cooperation in this matter.

The information obtained will be treated confidentially and only be used to determine eligibility.

1. Applicant's name _____ Date of birth ____ / ____ / ____

2. Medical diagnosis of disability or health condition:

3. Is the disability temporary? Yes No

If "Yes," the expected duration is until: ____ / ____ / ____

4. Please review the applicant's responses to his/her completed application. To the best of your knowledge, is the information about the applicant's disability and mobility accurate? Yes No

5. Are there any other effects of the applicant's disability or health condition of which we should be aware? _____

Name of professional _____ Title _____

Facility _____ Office telephone # _____

Address _____

City _____ State _____ Zip _____

By signing this form, I verify that the information provided is true and correct.

Signature _____ Date ____ / ____ / ____

Request for Professional Verification