

# ***“The Bus”***

## ***Request for Certification of Americans with Disabilities Act (ADA) Paratransit Eligibility***

The information in this certification process will only be used by the “The Bus” for the provision of transportation services. Information regarding the evaluation of your functional ability to use transit services will only be shared with other transit providers to facilitate travel in those areas. The information will not be provided to any other person or agency. PLEASE COMPLETE AND RETURN THIS FORM TO:

MERCED COUNTY TRANSIT “THE BUS”  
850 THORNTON ROAD  
MERCED, CA 95341

1. Name: \_\_\_\_\_

2. Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

3. Telephone :( Home) : \_\_\_\_\_ ( Cell) \_\_\_\_\_

4. In Case of Emergency, notify:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

5. Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ (if you are a senior citizen, age 60 or older, stops here and proceeds to #8)

***Operators will assist you on and off vehicles, but will not go into residences.***

Disability Information:

6. What is the functional limitation that prevents you from using our fixed route services?

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Is this condition temporary? Yes \_\_\_ No \_\_\_  
If yes, expected duration until \_\_\_/\_\_\_/\_\_\_

7. How does this disability prevent you from using fixed route services? Please explain completely. Use an additional sheet if needed.

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THE FOLLOWING INFORMATION WILL BE USED TO ENSURE THAT AN APPROPRIATE VEHICLE IS UTILIZED TO PROVIDE YOUR TRANSPORTATION AND THAT AN ACCURATE ANALYSIS OF YOUR TRIP REQUEST CAN BE MADE BY "THE BUS."

8. Which of these mobility aids or equipment do you utilize?

\_\_\_ Cane    \_\_\_ Manual Wheelchair    \_\_\_ Power Wheelchair  
\_\_\_ Walker    \_\_\_ Scooter    \_\_\_ Crutches  
\_\_\_ Service Animal (describe) \_\_\_\_\_

If Care Attendant is required please check here \_\_\_\_\_

If you use a wheelchair or scooter, please list measurements

Length \_\_\_\_\_ inches    Width \_\_\_\_\_ inches

Does the total weight of your wheelchair/scooter and yourself exceed 600 pounds? Yes \_\_\_\_\_ No \_\_\_\_\_

9. Do you currently use any other transit or paratransit service in the region?

Yes \_\_\_\_\_ No \_\_\_\_\_ Please list Name of services:

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10. Can you climb up and down three 12-inch steps to get on and off of a bus? Yes \_\_\_ No \_\_\_ Sometimes \_\_\_

11. What is the maximum period you can wait outside without support?  
\_\_\_\_\_ Minutes

12. Is this time period affected by extremes of hot or cold weather?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe your situation:

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***I hereby certify that the information given above is correct.***

Sign: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

If this application has been completed by someone other than the person requesting certification, that person must complete the following:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Sign: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## ***Request for Professional Verification***

***The attached authorization form has been submitted by \_\_\_\_\_, who has indicated that you can provide information regarding his/her disability and its impact upon his/her ability to utilize our transit services. Federal law requires that “The Bus” provide paratransit services to persons who cannot utilize available fixed route services. Must be completed by the primary physician treating the person named for verification. The information you provide will allow us to make an appropriate evaluation of this request and its application to specific trip requests. Thank you for your cooperation in this matter. Please return this completed form to:***

***Merced County Transit “TheBus”  
850 Thornton Rd  
Merced, CA 95341 Phone: 384-3111 Fax: 209-724-0253***

1. Capacity in which you know the applicant: \_\_\_\_\_

2. Medical Diagnosis of Condition causing disability: \_\_\_\_\_

3. Is this condition temporary? Yes \_\_\_\_ No \_\_\_\_

4. Expected Duration \_\_\_\_/\_\_\_\_/\_\_\_\_

5. If the person has a disability effecting mobility, is the person:

Able to walk 200 feet without assistance? Yes \_\_\_\_ No \_\_\_\_

Able to walk ¼ mile without assistance? Yes \_\_\_\_ No \_\_\_\_

Able to climb three 12-inch steps without assistance? Yes \_\_\_\_ No \_\_\_\_

Able to wait outside without support for 10 minutes? Yes \_\_\_\_ No \_\_\_\_

Does the person use any mobility aids? If so, what?  
\_\_\_\_\_

6. Does the person have visual impairment? Yes \_\_\_\_ No \_\_\_\_

Visual Acuity with Best Correction:

Right Eye \_\_\_\_ Left Eye \_\_\_\_ Both Eyes \_\_\_\_

Visual Fields:

Right Eye \_\_\_\_\_ Left Eye \_\_\_\_\_ Both Eyes \_\_\_\_\_

If the person has a cognitive disability, is the person able to:

- Give addresses and telephone number upon request? \_\_\_\_\_
- Recognize designation or landmark? \_\_\_\_\_
- Deal with unexpected situations or unexpected changes in route? \_\_\_\_\_
- Ask for, understand, and follow directions? \_\_\_\_\_
- Safely and effectively travel through crowded and / or complex facilities? \_\_\_\_\_

Is there any other effect of the disability of which “The Bus” should be aware of?

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Primary Physician’s Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Primary Physician’s  
Signature: \_\_\_\_\_