PLEASE READ BEFORE COMPLETING THE APPLICATION
If you have any questions regarding this application, please contact the Paratransit Certification/Enrollment Office at (770) 429-7855.

Dear Applicant:

The questions in **PART A** of this application represent the first step in the process to certify your application for eligibility to use CobbLinc's Paratransit Service. Please answer each question to assist us in determining the appropriate service to match your abilities. **A DISABILITY DOES NOT AUTOMATICALLY MAKE SOMEONE ELIGIBLE FOR PARATRANSIT SERVICE.** Eligibility for ADA Complementary Paratransit service is determined by your functional ability to ride or access the fixed route accessible bus service. It is not a medical determination; it is a functional ability analysis. A disability that makes travel more difficult, but not impossible, does not qualify you for eligibility.

It is your responsibility to return the completed and signed **PART A to CobbLinc**. You must sign the Authorization Page of this form authorizing your Licensed/Certified Professional to release information regarding your disability and functional ability to access and use the accessible fixed route bus service. **On the Authorization Page, please be certain to provide complete information including correct fax number of the Licensed/Certified Professional who can appropriately answer questions about your disability and your functional ability to travel**. It is strongly recommended that the Licensed/Certified Professional be someone who is familiar with your functional ability. In other words, a family medical doctor may have less knowledge about a person who has:

- A mental health disability as opposed to a counselor, psychologist or psychiatrist;
- A visual impairment as opposed to a mobility specialist;
- A developmental disability as opposed to a case manager or supportive employment specialist;
- A mobility impairment as opposed to a physical therapist or occupational therapist.

When the completed **PART A** is received by CobbLinc, **PART B** of the application will be faxed by the CobbLinc Certification Administrator to the Licensed/Certified Professional who was listed by you in PART A. Your application will be considered complete once your Licensed/Certified Professional has completed and returned PART B to CobbLinc. If your Licensed / Certified Professional does not return Part B of the application back to CobbLinc within **10-15 business days** your application will be denied. CobbLinc will provide a decision as to your eligibility within 21 business days, once the completed application **(Part A & Part B) is received**.

Please note: the person filling out PART A of this application cannot be the same person who completes PART B as the Licensed/Certified Professional.

All questions must be completed to process this application.
Use N/A (Not Applicable) if the question does not apply to you.

GENERAL INFORMATION (Please Print)

Please circle one: New Application Re-Certification Application

Last Name: _____First Name: _____ M. I. : _____

Residential Address: _____Apt/Lot#_____

City: _____ State: _____Zip: _____ County: _____

Is the provided address your mailing address? ☐ Yes ☐ No Email: _____

If not, please provide mailing address: _____

Daytime Phone #: _____ Alternate Phone #: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Emergency Contact: _____ Relationship: _____ Phone #: _____

Indicate the following residence type in which you live:

☐ Single Family Home ☐ Apartment/ Townhouse ☐ Retirement Facility ☐ Assisted Living Facility ☐ Skilled Nursing Facility

Name of facility, if applicable: _____

When you travel outside your home, please check which (if any) of the following mobility aids you use.

☐ Power Wheelchair
☐ Manual Wheelchair
☐ Power Scooter
☐ Walker
☐ Cane
☐ Crutches
☐ White Cane
☐ Respirator
☐ Stretcher
☐ Service Animal
☐ Personal Care Attendant
☐ Other_____

If you use a manual wheelchair, can you transfer to a passenger seat for travel? ☐ Yes ☐ No ☐ N/A

Are you a disabled veteran? ☐ Yes ☐ No (If yes, please attach a copy of VA letter of disability)

SECTION A – The Americans with Disabilities Act

A1. Can you use the CobbLinc fixed route bus? ☐ YES ☐ No

A2. Please describe the condition, disability, or limitation that prevents you from riding the CobbLinc fixed route bus. _____

_____

_____

A3. Is this condition/disability/limitation: ☐ Permanent ☐ Temporary

If temporary, how long do you expect it to last? _____

A4. With your mobility aids, if applicable, how far can you travel?

- ☐ I can only get to the curb in front of my residence
- ☐ I can travel up to two or three blocks
- ☐ I can travel up to six blocks
- ☐ I can travel more than six blocks
- ☐ Not Applicable

A5. What is the longest time you can wait outside under the following conditions:

With a place to sit?

☐ 5 minutes or less ☐ 15 minutes ☐ 30 minutes ☐ More than 30 minutes

Without a place to sit?

☐ 5 minutes or less ☐ 15 minutes ☐ 30 minutes ☐ More than 30 minutes

A6. Can you step up and down off curbs when you travel between city blocks and/or cross streets?

☐ Yes No ☐

A7. If you cannot use steps to board a bus, can you board a bus using any of the following? (Please note that persons who cannot climb the bus steps have the right to enter the bus by standing on the lift.)

A wheelchair lift? ☐ Yes ☐ No
A ramp (incline)? ☐ Yes ☐ No
If neither, please explain_____

A8. Are you able to give your address and phone number upon request? ☐ Yes ☐ No

A9. Are you able to ask for, understand, and follow directions? ☐ Yes ☐ No If No, please explain:

_____

_____

A10. Are you able to travel safely and effectively through crowded and/or complex facilities? ☐ Yes ☐ No

A11. How do you currently travel to your frequent destinations?

- ☐ CobbLinc fixed route bus
- ☐ Uber / Lyft
- ☐ Walk Other_____
- ☐ Family
- ☐ I drive myself

A12. Do you travel with the help of another person? ☐ Always ☐ Sometimes ☐ Never

A13. Are you able to get to and from the public transit stop nearest your home? ☐ Yes ☐ No

If No, please explain: _____

_____

A14. If you have a service animal, indicate the task(s) your service animal performs for you:

- ☐ Guides me
- ☐ Alerts me
- ☐ I do not currently use a service animal
- ☐ Picks up items
- ☐ Pulls me
- ☐ Carries items for me (explain) _____
- ☐ Other: _____

Type of animal: _____

PATIENT CONSENT FOR RELEASE & DISCLOSURE OF MEDICAL INFORMATION

(Please give **COMPLETE INFORMATION ABOUT THE LICENSED/CERTIFIED PROFESSIONAL** authorized to complete Part B of your application. The following Licensed/Certified Professionals are authorized to complete Part B: Physician, Registered Nurse, Social Worker, Psychologist, Physical Therapist, Chiropractor, Occupational Therapist, Speech Pathologist, Special Education Teacher, Nurse Practitioner, Physician's Assistant, Mental Health Counselor, Orientation/Mobility Specialist, Respiratory Therapist, Vocational Rehabilitation Counselor, or Recreation Therapist employed by a medical facility).

This Consent to Release Medical Information is to be provided to: **CobbLinc Paratransit**

Name & Title of Licensed/Certified Professional:

NAME/TITLE:_____

ADDRESS: _____

CITY:_____ STATE: _____ ZIP:_____

PHONE #: (___)_____ FAX #: (___)_____

I, the undersigned, do hereby consent to the release and disclosure of any relevant medical information to CobbLinc Paratransit Services as called for in Part B of this application for the sole purpose of determining ADA paratransit eligibility. I understand that this information will be shared only with persons making decisions related to my eligibility for paratransit services and to other transit providers needing such information to facilitate travel.

I have read this document carefully and understand that I have the right to revoke this release in writing, excepting information that may have previously been released under this authorization.

_____ _____
Signature of applicant, representative, or guardian Date

_____ _____
Witness Date

If someone other than the applicant has completed this application/authorization, that person must complete the following:

Name _____

Relationship _____

Address _____

Home phone _____

Work phone _____

TDD/TTY _____

I certify, to the best of my knowledge that the information provided in this application is complete and correct based upon the information given to me by the applicant or my own knowledge of the applicant's health condition or disability.

Signature _____ Date _____

FOR COBBLINC OFFICE USE ONLY:

APPROVED_____ CONDITIONAL_____ UNCONDITIONAL _____

CODE(S) _____

DENIED_____

LIST SPECIFIC REASON FOR DENIAL THAT WILL BE STATED ON THE DENIAL LETTER_____

_____

_____

_____

_____

SIGNED_____DATED_____