If you have any questions regarding this application please contact the Paratransit Certification/Enrollment Office at (770) 429-7855.

ACKNOWLEDGEMENT OF ADA PARATRANSIT CERTIFICATION

The person named on the attached application has applied for COBBLINC Paratransit Service. COBBLINC provides two levels of transportation service to the public, both fixed route and paratransit.

THE ENTIRE FLEET OF COBBLINC BUSES ARE ACCESSIBLE AND ADA COMPLIANT.

Fixed Route

Accessible fixed route service is available to all citizens. All buses are equipped with:

- low floor ramp or lift (for wheelchairs and those who cannot climb stairs),
- internal and external audio enunciators (operators make additional announcements as requested)
- Internal and external signs displaying route information.

Accessible, covered, transfer centers provide shelter and seating. Schedules and other information are available in a variety of formats to ensure accessibility. Most bus stops have shelters and seating, however, paths of travel to all bus stops rely on surrounding terrain.

Paratransit

Paratransit service is an origin to destination, lift accessible, and shared-ride public transportation service. The ADA statute clearly emphasizes nondiscriminatory access to fixed route service, with ADA Complementary Paratransit acting as a "safety net" for people who do not have the functional ability to use the fixed route system. Under ADA guidelines, Complementary Paratransit service is **not** intended to be a comprehensive system of transportation for individuals with disabilities, and **simply having a disability or multiple disabilities does not, in and of itself, entitle a person to ride.** Rather, the DOT ADA regulations provide for three categories of ADA Complementary Paratransit Eligibility:

- persons with disabilities who cannot use fixed route without the assistance of another person,
- persons who could use the fixed route if the vehicles were accessible, and
- any individual with a disability who has a specific impairment-related condition, which prevents such individual from traveling to a boarding location or from a disembarking location on such system.

The determining factor in deciding whether a person qualifies for *ADA Complementary Paratransit* Service is whether he/she can functionally ride or access the bus. It is not a medical determination; it is a functional ability analysis.

In order to expedite the processing of this application, COBBLINC requests that you please fill out and **fax** back Part B of this application within 3 business days of receipt of the application by your office to **(770) 429-7865**.

This portion MUST be completed by one of the following currently Licensed/Certified Professionals:

Physicians, 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.

COBBLINC PARATRANSIT APPLICATION PART B: TO BE FILLED OUT BY A LICENSED/CERTIFIED PROFESSIONAL

General Information

Name of Applicant:____ Date of Birth __________

Date of applicant's last assessment or interaction with you ________________________

Please fill out the requested information.

List the Medical Names of Your Disabilities or Medical Conditions	Is the Condition Permanent?	Duration of Condition	Medications taken for the Condition
	Yes ☐ No ☐		
	Yes ☐ No ☐		
	Yes ☐ No ☐		
	Yes ☐ No ☐		
	Yes ☐ No ☐		

1. Please discuss the impact this disability has on the applicant's **functional ability** to ride a COBBLINC assessable (big), fixed route bus. ____

____

____

2. If this is a temporary disability, when will the applicant be able to resume normal travel patterns? Please list an actual date ____

____

3. Under what circumstance does the disability worsen? ____________________________

____

4. Does the applicant have the mental capacity, visual and/or hearing ability to:

   Give addresses and phone numbers? ____

   Recognize a destination or landmark? ____

   Deal with unexpected change in routine? _________________________________

   Ask for, understand and follow directions? ________________________________

Safely/effectively travel through crowded/complex facilities? ______________________

5. Does the applicant require a Personal Care Attendant? ☐ Yes or ☐ No
6. Are there any other medical conditions of which COBBLINC should be aware?
   Yes ☐ No☐ If yes, please explain____

____

This certification information completed by:

Print name of certifying professional ____

Title ____

Address ____

City ______________________________ State _________________ Zip _____________

Office Phone Number (   ) _________________ Fax (   )____________________

E-mail Address ____

License/Certification # and State____

What organization issued your License? _______________________________

Signature_______________________________ Date signed _______________________

PLEASE RETURN BY FAX TO (770) 429-7865.