



# BRITE Transit



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## BRITE Access ADA Paratransit Application

In compliance with the American Disabilities Act (ADA), BRITE provides shared ride, advanced reservation, origin to destination service for disabled individuals who are unable to use regular fixed route public transportation services because of their disabilities.

To be eligible for service, the functional limitations of an individual's disability must prevent use of regular fixed route buses. BRITE Access paratransit service is available to any person with a disability who has specific impairment related condition that prevents the person from traveling to or from a boarding/disembarking location.

Please be aware that BRITE provides two types of public transportation:

1. Fixed Route buses provide service at designated bus stops along specific routes according to set schedules. All fixed route buses have features to make riding easier for people with disabilities including mobility device lifts and handrails for entering and exiting the bus.
2. Paratransit Service is a shared ride, advanced reservation, origin to destination public transportation service for people whose disability prevents them from riding fixed route buses. You must receive certified approval to use this service and must call in advance to make a reservation to travel.

**Applications MUST BE CERTIFIED by a licensed or certified health care professional every 2 years and within 30 days of expiration.**

Your ability to ride fixed route buses will be evaluated through use of the application, and in some circumstances, an in-person interview. Each application will be evaluated on a case-by-case basis, taking into consideration all of the information provided.

Applications are processed in the order in which they are received. A determination will be made within 21 days of receipt of the application and you will be notified of this decision in writing.

**It is very important that the application be filled out completely. Incomplete and illegible applications will not be processed and will be returned. Applications must have original signatures, as faxed or photocopied signatures are not permitted.**

If you have any questions concerning this application or paratransit services, please contact our office at: (540) 943-9302 or toll free at (800) 305-0077.

Please mail your completed application to: BRITE Transit Facility  
Attn: BRITE Access Applications  
51 Ivy Ridge Lane  
Fishersville, VA 22939



## BRITE Access ADA Paratransit Transportation Application

### PART I: GENERAL INFORMATION

Name:	_____	_____	_____
	(Last)	(First)	(Middle Initial)
Address:	_____		_____
			(Apt or Bldg#)
(City)	(State)	(Zip Code)	(County)
Mailing Address (If Different):	_____		_____
			(Apt or Bldg#)
(City)	(State)	(Zip Code)	(County)
Home Phone:	_____	Work Phone:	_____
Social Security Number:	_____	Date of Birth:	_____
	(Last 4 Digits Only)		
<u>Emergency Contact</u>			
Name:	_____	Relationship:	_____
Home Phone:	_____	Work Phone:	_____

Are you eligible for :  Medicaid or  Medicare

Are you a customer of another Paratransit system? \_\_\_\_\_  
(Name of System)

#### **For Office Use Only**

ID# \_\_\_\_\_ Expiration Date: \_\_\_\_\_

(Circle) Approved / Denied By: \_\_\_\_\_

Date: \_\_\_\_\_

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## **PART II: USING FIXED ROUTE SERVICES**

### **1. Please check all applicable boxes of mobility aids or equipment you currently use.**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Walking Cane                      | <input type="checkbox"/> Walker                  | <input type="checkbox"/> Powered Scooter/Cart                   |
| <input type="checkbox"/> Orthopedic Cane (3-4 Prong)       | <input type="checkbox"/> Leg Braces              | <input type="checkbox"/> Respirator/Oxygen Tank                 |
| <input type="checkbox"/> Long White Cane (Vision Impaired) | <input type="checkbox"/> Manual Mobility Device  | <input type="checkbox"/> Other                                  |
| <input type="checkbox"/> Service/Guide Animal              | <input type="checkbox"/> Powered Mobility Device | <input type="checkbox"/> I do not require any assistive devices |

### **2. Have you ever used our fixed route services?**

- Yes, I typically ride \_\_\_\_\_ times a week.
- Yes, I have previously but stopped because: \_\_\_\_\_
- No, I have never used BRITE's fixed route services.
- No, but I would be interested in learning how to use your regular service.

### **3. How far from your home is the nearest BRITEbus stop?**

- |  |   |
|--|---|
| <input type="checkbox"/> Less than 1 block | <input type="checkbox"/> 5 or more blocks |
| <input type="checkbox"/> 1 - 2 blocks      | <input type="checkbox"/> I do not know    |
| <input type="checkbox"/> 3 - 4 blocks      |   |

### **4. On your own, or using your assistive device, how far can you travel on level ground?**

- |  |  |
|--|--|
| <input type="checkbox"/> I can get to the curb in front of my house/apartment. | <input type="checkbox"/> I can travel up to 6 blocks (1/2 mile). |
| <input type="checkbox"/> I can travel up to 3 blocks (1/4 mile).               | <input type="checkbox"/> I can travel up to 9 blocks (3/4 mile). |

### **5. WITHOUT the help of someone else can you:**

- |   |                              |                             |                                    |
|---|------------------------------|-----------------------------|------------------------------------|
| Ask for, understand, and follow written or spoken instructions?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| Cross the street, either on your own or with an assistive device? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| Stand for 30 minutes if there is no place to sit?                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| Step on and off a sidewalk from the curb?                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| Find your own way to the bus stop if shown the way?               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| Walk up and down three steps if there is a handrail?              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| Stand on a moving bus if holding on to a handrail?                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |

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**6. Please explain how your disability prevents you from using BRITE's fixed route services.**

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## **PART III: APPLICANT CERTIFICATION**

I certify to the best of my knowledge and ability, the information in this application is true and correct. I hereby authorize permission to the licensed health care professional to release any relevant information for the purpose of evaluating my eligibility to use BRITE Access ADA paratransit services.

I understand that approval of this certification will be for a term of 2 years and it is my responsibility to initiate recertification within 30 days of expiration.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this application was completed for you by another person, please provide the following information.

Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

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

Agency or Clinic (if applicable): \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## PART IV: PROFESSIONAL CERTIFICATION

This portion **MUST BE COMPLETED** by a licensed  
or certified health care professional

The Americans with Disabilities Act of 1990 (ADA) requires the provision of paratransit service to **anyone who is prevented from using the regular transit system, by reason of physical or mental limitation, and who is traveling in an area served by the system.**

The applicant who has asked you to review and sign this form is seeking eligibility for BRITE Access ADA Paratransit Transportation service. This application is intended to determine whether applicant can use regular transit services or whether he/she requires origin to destination service.

**Resources for this program are limited so please exercise care in evaluating this applicant. Your evaluation must be based solely upon the applicant's ability to use regular transit services. False verification could result in travel limitations for persons legitimately qualified to use this program.**

Please carefully review the information provided by the applicant and answer the questions below.

Name of Applicant: \_\_\_\_\_

**1. Please mark all disabilities which prevent the applicant from using BRITE's fixed route bus services. Conditions that make it difficult or uncomfortable should not be checked.**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Muscular Dystrophy  | <input type="checkbox"/> Quadriplegia        |
| <input type="checkbox"/> Amputation         | <input type="checkbox"/> Paraplegia          | <input type="checkbox"/> Spina Bifida        |
| <input type="checkbox"/> Cerebral Palsy     | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Stroke/Brain Injury |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Polio               | <input type="checkbox"/> Other: _____        |

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Arteriosclerosis              | <input type="checkbox"/> Congestive Heart Failure    | <input type="checkbox"/> Thrombosis (Chronic) |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Emphysema                   | <input type="checkbox"/> Other: _____         |
| <input type="checkbox"/> Chronic Obstructive Pulmonary | <input type="checkbox"/> Heart Attack                |   |
| <input type="checkbox"/> Cystic Fibrosis               | <input type="checkbox"/> Peripheral Vascular Disease |   |

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- Alzheimer's Disease
- Autism
- Dementia
- Head Trauma
- Panic Disorder
- Phobia
- Schizophrenia
- Other: \_\_\_\_\_

- AIDS
- Diabetes (Severe)
- Cancer
- Lupus
- Epilepsy (Severe)
- Kidney Disease
- Skin Disorder
- Other: \_\_\_\_\_

- |                       |                              |                               |                    |                              |                               |
|-----------------------|------------------------------|-------------------------------|--------------------|------------------------------|-------------------------------|
| Cataracts             | <input type="checkbox"/> One | <input type="checkbox"/> Both | Retinal Detachment | <input type="checkbox"/> One | <input type="checkbox"/> Both |
| Glaucoma              | <input type="checkbox"/> One | <input type="checkbox"/> Both | Retinopathy        | <input type="checkbox"/> One | <input type="checkbox"/> Both |
| Legally Blind         | <input type="checkbox"/> One | <input type="checkbox"/> Both | Totally Blind      | <input type="checkbox"/> One | <input type="checkbox"/> Both |
| Muscular Degeneration | <input type="checkbox"/> One | <input type="checkbox"/> Both | Other:             | _____                        |                               |

**2. What disability prevents the applicant from riding the regular bus system? A detailed diagnosis is required. Please be as specific as possible without using diagnostic codes.**

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**3. Describe how this disability affects the applicant's functional ability to ride the regular bus system:**

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**4. Is this condition permanent or temporary? If temporary, what is the expected duration?**

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## 5. Does the applicant's disability require that he/she travel with an attendant?

- Yes  
  No  
  Sometimes (Please Explain Below):

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## 6. Is the applicant able to travel to and from a bus stop?   Yes   No (if no, please indicate all that apply)

- Cannot negotiate if the street or sidewalk is too steep.  
 Cannot travel if there are no curb cuts.  
 Cannot cross busy streets and intersections.  
 Cannot tolerate extreme temperatures.  
 Cannot locate bus stop due to a visual impairment.  
 Cannot wait outside without support for 15 minutes.  
 Becomes confused easily and may get lost  
 Other: \_\_\_\_\_

## 7. Indicate the individual's ability to independently perform the following functions using the most effective mobility aid.

	Little to no difficulty	Discomfort and some difficulty	Severe pain and difficulty	Impossible and likely to cause medical crisis
Find own way home between familiar locations				
Handle money or tickets				
Provide address and telephone numbers upon request				
Recognize a destination or landmark				
Ask for, understand, and follow directions				
Travel 200 feet (city block)				
Travel 1/4 mile (three blocks)				
Deal with unexpected situations or unexpected changes in routine				
Safely and effectively travel through crowds and complex facilities				

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**Applications with illegible or incomplete information will be returned.  
Please use medical office stamp if available.**

**Person Completing Certification:** \_\_\_\_\_

**Professional Title:** \_\_\_\_\_

**Business Address:** \_\_\_\_\_

**Clinic or Agency:** \_\_\_\_\_

**Business Telephone:** \_\_\_\_\_

**I verify that the information provided for verification is true and correct.**

\_\_\_\_\_  
**(Signature)**

\_\_\_\_\_  
**(Printed Name)**

\_\_\_\_\_  
**(Date)**