CLINTON COUNTY PUBLIC TRANSIT

ADA Paratransit Individual Application Form (double-sided) Last Revised 7/14/2015

Once completed, please return to **Clinton County Planning Office, 135 Margaret Street Suite 124, Plattsburgh NY 12901**

Please refer to the instructions for filling out this form. If you have questions please call (518) 565-4713. For TDD relay for the hearing impaired call 1 (800) 662-1220.

1. Your Name (Please print): ____

Last First Middle Initial

2. Your home address: ____

Number Street Apartment Number if Applicable

________________ ____ __________

City State Zip Code

3. Your mailing address (if different than home address): ______________________________

Number and Street and Apartment Number

________________ ____ __________

City State Zip Code

4. Your Telephone Numbers: Home:____________ Cell:___________ Work:____________

5. Your date of birth: ________________ (Month / Day / Year)

6. Your Medicaid # (if applicable): ________________________

7. What disabilities do you have which prevent you from using the regular bus system? Please check all that apply and specify the disabilities:

❒ Cognitive Impairment such as Alzheimer's, Dementia, Dyslexia, Down Syndrome, Mental Retardation, Traumatic Brain Injury, etc.: ____

❒ Mental/Emotional/Behavioral Disorder such as Anxiety Disorder, Autism Spectrum Disorders, Conduct Disorder, Mental Illness, Panic Disorder, Schizophrenia, etc.: ______________________________

❒ Need for physically draining medical treatments such as Chemotherapy, Dialysis, Radiation, etc.:

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❒ Physical Disability such as dependency on a mobility aid including a cane, rollator, walker, or wheelchair, cardiovascular impairment, limited ambulation/mobility, paralysis, short of breath, etc.:

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❒ Seizures or Dizziness: ____

❒ Visual Impairment such as legally blind, etc.: ______________________________

❒ Other: ____

8. Is your disability temporary or permanent? If temporary, when will the disability end?

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9. How does your disability or disabilities prevent you from using the regular bus system? Please check all that apply:
Due to disability, applicant cannot…

❒ … read and/or understand the bus schedule.

❒ … navigate the regular bus system safely such as changing buses.

❒ … safely and independently cross streets.

❒ … safely and independently travel ¼ mile (about four city blocks).

❒ … tolerate lengthy bus trips at any time.

❒ … tolerate lengthy bus trips but only after certain medical treatments.

❒ … use the regular bus system during inclement weather.

❒ … travel up or down inclines to get between home and regular bus routes.

❒ … travel to locations not along a bus route.

❒ … use the regular bus system for the following reasons:

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10. Do you use any mobility aids? Please check all that apply:

❒ Cane	sometimes or always?	❒ Wallker/Rollator	sometimes or always?
❒ Crutches	sometimes or always?	❒ Manual Wheelchair	sometimes or always?
❒ Braces	sometimes or always?	❒ Electric Wheelchair	sometimes or always?
❒ Service Animal	sometimes or always?	❒ Power Scooter	sometimes or always?
❒ Personal Care Assistant	sometimes or always?	❒ Other: __________	sometimes or always?

Applicant's signature: I hereby certify that the above information provided on this form is true. I understand Clinton County Public Transit will make the final determination on my eligibility. I understand that if I disagree with my eligibility determination I have the right to appeal. I hereby release the information provided on this form for use by Clinton County Public Transit for the provision of transportation services. I authorize this information to be shared between the Clinton County Planning Office, CCPT management, dispatchers, and drivers as necessary for the provision of transportation service. I further authorize my medical care provider and/or a human service agency employee familiar with my situation to confirm the disability information I have provided.

Applicant's Signature: ___________________________________ Date: ____________

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Verification signature: Please print name: ____
Please check one of the following: I am a: ❒ Physician ❒ Nurse or other Medical Professional
❒ Licensed Clinical Social Worker ❒ Human Service Agency Employee (indicate agency): ______________________
I hereby confirm that I have reviewed the information provided on this form by the applicant and find it to be substantially accurate based on the information available to me in my professional capacity. I wish to add the following comments: ____

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Verification Signature: ___________________________________ Date: ____________