



Americans with Disabilities Act (ADA) Paratransit Application

Part A – to be completed by applicant or applicant’s representative.

The information given through this certification process will be used by HT RIDE, the Howard Transit Paratransit service, only to provide transportation services. The information *will not* be provided to any other person or agency for any other purpose. *You must live within ¾ mile of the fixed route transit service to qualify for HT RIDE.* This application is available in alternate formats upon request (see Part A, Section 12). **Both Part A (the application) and Part B (the medical questionnaire) must be completed in order for your application to be considered.** Part A and the first page of Part B are to be completed by the applicant or his/her representative (see Section 2), and the remainder of Part B is to be completed by a health care professional. **PLEASE PRINT ALL INFORMATION CLEARLY.** Incomplete or illegible submissions cannot be considered and will be returned.

Section 1 Applicant’s Personal Information (Required)

Name _____ Date of Birth _____
Address _____ City _____ State _____
Zip _____ Phone (_____) _____ Social Security Number* _____

* Disclosure of Social Security Number is voluntary (Privacy Act of 1974); it is used solely to identify the applicant.

Section 2 Preparer Information (Only if completed by someone other than applicant)

Name _____ Relationship to Applicant _____
Address _____ City _____ State _____ Zip _____
Day Phone (_____) _____ Signature _____ Date _____

Section 3 Applicant’s Condition (Required)

Describe your condition and how it limits your use of fixed route / regular transit services. Please be specific and explain completely. Use an additional sheet if needed. Please avoid abbreviations.

Is your condition temporary? Yes No Unknown
If yes, expected recovery date _____

Section 4 Accessibility (Required)

Section 10 may also allow you to explain your situation more fully.

1. Can you travel about 1/3 of a city block (200 feet) without help from another person? Yes No Sometimes

If No or Sometimes, please explain: _____

2. Can you travel about 3 city blocks (1/4 mile) without help from another person? Yes No Sometimes

If No or Sometimes, please explain: _____

3. Can you climb three 12-inch steps without help? Yes No Sometimes

If No or Sometimes, please explain: _____

4. Can you wait outside for a bus without help for 15 minutes? Yes No Sometimes

If No or Sometimes, please explain: _____

5. Can you travel to and from your home to fixed route or regular bus service? Yes No Sometimes

If No or Sometimes, please explain: _____

6. Can you travel to and from anticipated destinations to fixed route or regular bus service? Yes No Sometimes

If No or Sometimes, please explain: _____

7. Does the weather affect your ability to use fixed route or regular bus service? Yes No Sometimes

If Yes or Sometimes, please explain: _____

8. Are there any other barriers preventing or limiting your use of fixed route or regular bus service? Yes No Sometimes

If Yes or Sometimes, please explain: _____

9. If available, would you like training to use fixed route service? Yes No Undecided

10. Do you need a personal care attendant to assist you so you can travel on a bus? No Sometimes Always

If Sometimes, under what conditions? _____

If you travel with someone who regularly helps you, does this person assist you in:

- Getting to or from bus stops Getting on or off the bus (including recognizing buses and exits)

- Activities once you reach your destination Other (describe) _____

Section 5 Limited Income Provision (Optional)

If you feel that you qualify for Low Income Housing (Section 8) or for SSI Assistance, please check the appropriate box and **attach proof of income.** Yes No Unknown Remarks:

Section 6 Mobility Aids / Assistance Needed (Required)

(This information will be used by the HT RIDE service to plan trips and assign appropriate vehicles.)

Do you use any of the following aids? Check each one that applies. Cane Crutches

Walker Guide Dog Manual Wheelchair Electric Wheelchair Power Scooter

If you use a power scooter or wheelchair, is it larger than 30" x 48", or over 600 pounds when occupied? Yes No Not Applicable Unknown

Section 7 Emergency Contact Information (Required)

Name: _____ Phone (____) _____ Relationship _____

Section 8 Authorization to Contact Health Care Professional (Required)

In order to evaluate your request for ADA Paratransit eligibility through HT RIDE, verification is necessary by a qualified health care professional familiar with your disability and your ability to travel on the fixed route transit system. Identify the person and sign the authorizations here and on page 1 of Part B.

I authorize the following professional to release to HT RIDE information about my disability and its effect on my ability to travel on the fixed route transit system. I understand that the information released will be used solely to determine this eligibility, and that I may revoke this authorization at any time. Unless earlier revoked, this form will permit the person listed to release the information until 60 days after the date appearing below. "Health care professionals" include (please indicate one):

- Physician or registered nurse Physical or occupational therapist
- Social worker Mental health counselor Vocational rehabilitation counselor
- Rehabilitation specialist Independent living counselor Psychologist

Full Name _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Authorized by (signature): _____ Date: _____

Section 9 Certification of Completeness and Accuracy (Required)

I hereby certify, under the penalties of perjury, that the information given above is true and correct. I expressly acknowledge that HT RIDE will rely upon the information contained herein in making a determination as to my eligibility for participation in the program. I agree that if any of the information given to HT-RIDE is materially false or misleading, HT RIDE shall have the right to revoke or otherwise condition my right to participate in the paratransit program, in addition to pursuing any other right or remedy which the HT RIDE may have under the circumstances.

Applicant's Signature: _____ Date: _____

Section 10 Additional Information (Optional)

Answers to the following questions will be helpful in providing information Howard Transit and HT RIDE needs to plan routes, schedules, and stops in the future. We appreciate your taking the time to complete this section. Use the route maps and schedules enclosed to determine the following:

- What is the nearest major intersection to your home? _____
- Which current bus stop is nearest to your home? _____
- What is the approximate distance from your home to the nearest bus stop? _____
- Is your ability to travel this distance affected by snow ice rain heat air quality?
Other weather conditions? _____
- Is your ability to travel this distance affected by environmental conditions such as
 absence of sidewalks absence of ramps steep hills inadequate signs
 other conditions? _____
- Would you be better able to wait for a bus if there were a bench a shelter?
- Could you use the fixed route bus service sometimes? Yes No
If sometimes, under what conditions? _____
- Have you been able to use the fixed route service in the past but stopped?
 Yes No Sometimes
If Yes or Sometimes, why did you stop? _____
What are your most frequent destinations? _____
- Other comments: _____

Section 11 Deliver To:

Please ensure that both parts are complete and signed. Mail to:

Corridor Transportation Corporation
HT RIDE
312 Marshall Avenue, Suite 104
Laurel, MD 20707

Section 12 Contact Information

For Service/Reservations, Call:

HT-RIDE 410-313-1921
Howard Transit 410-313-1919

Other Information:

Disabilities Services 410-313-6402
TTY 410-313-6401
Office on Aging 410-313-7387/8/9
Community Action 410-313-6440
Maryland Relay 1-800-735-2258

Questions/Concerns: 410-313-3707



Americans with Disabilities Act Paratransit (ADA) QUESTIONNAIRE

Part B – to be completed by qualified health care professional.

As part of the initial submission, the HT RIDE eligibility process requires evaluation by a *licensed physician, rehabilitation professional, or other qualified health care professional* (see Section 2) who is familiar enough with the applicant’s condition to evaluate his/her ability or inability to use the regular fixed route bus service. While this evaluation is a necessary part of the certification process, determination of eligibility is the decision of the HT RIDE program.

Please ensure that both parts are complete and signed; otherwise the submission is considered incomplete and the applicant cannot be certified as eligible for the paratransit service.

Section 1 Applicant’s Personal Information (Required - completed by applicant)

Name _____ Date of Birth _____
Address _____ City _____ State _____
Zip _____ Phone (_____) _____ Social Security Number* _____

Section 2 Applicant’s Authorization for Release of Medical Information (Required - completed by applicant)

I authorize the following professional to release to HT RIDE information about my disability and its effect on my ability to travel on the fixed route transit system. I understand that the information released will be used solely to determine this eligibility, and that I may revoke this authorization at any time. Unless earlier revoked, this form will permit the person listed to release the information until 60 days after the date appearing below. “Health care professionals” include (please indicate one):

- Physician or registered nurse Physical or occupational therapist
- Social worker Mental health counselor Vocational rehabilitation counselor
- Rehabilitation specialist Independent living counselor Psychologist

Full Name _____ Phone (_____) _____
Address _____ City _____ State _____ Zip _____
Authorized by (signature): _____ Date: _____

PLEASE PRINT ALL INFORMATION CLEARLY, AND COMPLETE ALL SECTIONS ON THE FOLLOWING PAGES.

Section 3 Applicant's Condition (Required - completed by health care professional)

Describe the individual's condition and how it limits his/her use of fixed route or regular transit services. Please be specific and explain completely in non-clinical terms. Please avoid abbreviations.

Is the condition temporary? Yes No Unknown If yes, expected recovery date _____

Section 4 Accessibility (Required - completed by health care professional)

1. Can this individual travel about 1/3 of a city block (200 feet) without help from another person?
 Yes No Sometimes

If No or Sometimes, please explain: _____

2. Can he/she travel about 3 city blocks (1/4 mile) without help from another person?
 Yes No Sometimes

If No or Sometimes, please explain: _____

3. Can he/she climb three 12-inch steps without help?
 Yes No Sometimes

If No or Sometimes, please explain: _____

4. Can he/she wait outside for a bus without help for 15 minutes?
 Yes No Sometimes

If No or Sometimes, please explain: _____

5. Can the applicant travel to and from his/her home to fixed route or regular bus service?
 Yes No Sometimes

If No or Sometimes, please explain: _____

6. Can he/she travel to and from anticipated destinations to fixed route or regular bus service?
 Yes No Sometimes

If No or Sometimes, please explain: _____

7. Does the weather affect his/her ability to use fixed route or regular bus service?
 Yes No Sometimes

If Yes or Sometimes, please explain: _____

8. Are there any other barriers preventing or limiting use of fixed route or regular bus service?
 Yes No Sometimes

If Yes or Sometimes, please explain: _____

9. If available, could the individual be trained to use fixed route service? Yes No Unknown

10. Does the person need a personal care attendant (a "PCA" -- someone who regularly assists him or her) to make bus travel possible?

No Sometimes Always

If Sometimes, under what conditions? _____

If the Applicant travels with a PCA, does the PCA assist him/her in: Not Applicable

Getting to or from bus stops Getting on or off the bus (including recognizing buses and exits)

Activities once at the destination Other (describe) _____

11. Is the applicant able to ask for, understand, and follow written or spoken directions or schedule information either independently or with the help of an aid (such as a card)?

Yes No Sometimes

If No or Sometimes, please explain: _____

12. Can the Applicant recognize landmarks, select and navigate bus routes, etc., without help?

Yes No Sometimes

If No or Sometimes, please explain: _____

13. Can the Applicant deal with unexpected situations?

Yes No Sometimes

If No or Sometimes, please explain: _____

Section 5 Mobility Aids/ Assistance Needed (Required - completed by health care professional)

This information will be used by the HT RIDE service to plan trips and assign appropriate vehicles.

Does the Applicant use any of the following aids? Check each one that applies. Cane

Crutches Walker Guide Dog Manual Wheelchair Electric Wheelchair

Power Scooter Other _____

If the person uses a power scooter or wheelchair, is it larger than 30" x 48", or over 600 pounds when occupied? Yes No Not Applicable Unknown

If using a wheelchair, can the person transfer to a car or van with little or no help?

Yes No Not Applicable Unknown

Section 6 Additional Comments/Suggestions (Optional -completed by health care professional)

Section 7 Physician/Health Care Professional Certification (Required - completed by health care professional)

I hereby certify, under the penalties of perjury, that the information given above is true and correct. I expressly acknowledge that HT RIDE will rely upon the information contained herein in making a determination as to the applicant's eligibility for participation in the program. I agree that if any of the information given to HT RIDE is materially false or misleading, HT RIDE shall have the right to revoke or otherwise condition the applicant's right to participate in the paratransit program, in addition to pursuing any other right or remedy which may have under the circumstances. It is my professional opinion that the applicant has a disability.

Name _____ physician Case Manager R.N.
 LCSW PT OT counselor other health care professional _____

Address _____

City _____ State ____ Zip _____ Phone (____) _____ Fax (____) _____
License/Certification # _____ Signature _____ Date _____

Section 7 Deliver To:

Please ensure that all parts are complete and signed. Mail to:

Corridor Transportation Corporation
HT Ride
312 Marshall Avenue, Suite 104
Laurel, MD 20707

Section 8 Contact Information

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|---------------------------------|--------------|-----------------------|------------------|
| For Service/Reservations, Call: | | Other Information: | |
| HT RIDE | 410-313-1921 | Disabilities Services | 410-313-6402 |
| Howard Transit | 410-313-1919 | TTY | 410-313-6401 |
| | | Office on Aging | 410-313-7387/8/9 |
| | | Community Action | 410-313-6440 |
| Questions/Concerns: | 410-313-3707 | Maryland Relay | 1-800-735-2258 |