APPLICATION FOR CERTIFICATION OF AMERICANS WITH DISABILITIES ACT ELIGIBILITY

The information obtained in this certification process will only be used by SWRTA for the provision of ADA transportation services in Sumter, Lee and Kershaw counties. The information will not be provided to any other agency.

DATE OF APPLICATION

☐☐ / ☐☐ / ☐☐

Recertification is required every two (2) years.

☐ **NEW**
☐ **RECERTIFICATION**

This portion is to be filled out by applicant - Please print.

PERSONAL INFORMATION

Full Name :

Home Address :

Date of Birth : ☐☐ / ☐☐ / ☐☐ **Mailing Address:**

Email : **City/State/Zip :**

Gender : ☐ **Male** ☐ **Female**

Daytime Phone : **Cellular Phone:**

TTD/TTY Number:

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:

Daytime Phone : **Cellular Phone :**

Home Address: **Email Address :**

City, State, Zipcode :

OFFICE USE ONLY

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ADA Eligibility Approved? _____ ID Card#_____ Effective Date_____ Expiration Date_____

Decision Letter mailed _____ Personal Care Attendant/Escort Approved_____

SWRTA Staff Member Name _____ Date _____

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Santee Wateree
Regional Transportation Authority

DISABILITY AND MOBILITY EQUIPMENT

This portion is to be filled out by applicant - Please print.

1. Which of the following limit your ability to use SWRTA's fixed route bus service?
(Check all that apply)

- ☐ Physical disability
- ☐ Low vision/blindness
- ☐ Developmental disability
- ☐ Psychiatric disability
- ☐ Intellectual disability
- ☐ Other

2. Which of these mobility aids or equipment do you use to help you get where you need to go?
(Check all that apply)

- ☐ None
- ☐ Communication Device
- ☐ Cane/Walker/Crutches
- ☐ Powered scooter/cart
- ☐ Power wheelchair
- ☐ Manual wheelchair
- ☐ White cane
- ☐ Hearing aid
- ☐ Service animal
- ☐ Portable oxygen
- ☐ Other

3. Please describe your disability (or disabilities) in more detail:

_____
_____
_____
_____

4. How does the disability (or disabilities) listed above prevent you from using SWRTA's fixed route bus service?

_____
_____
_____
_____

I verify that all statements are true and correct to the best of my knowledge. I understand that supplying false information can disqualify my application and/or subsequent registration. I authorize SWRTA to obtain verification of any information given in this application and to obtain essential medical information necessary for determination of eligibility. I understand that only the information required to provide paratransit services will be disclosed to those who perform those services. I understand that if any portion of this application changes, including mobility devices, I will notify the SWRTA ADA office immediately. I understand that SWRTA may contact the licensed medical professional who has completed the Professional Verification Form application in order to confirm or clarify this information.

Signature_____ Date____/____/_____

RELEASE OF INFORMATION

The following Health Professional_____ is familiar with my disability and is authorized to provide the information to SWRTA's ADA service required to complete this certification.

Name_____

Address_____

City _____State _____ Zip_____

Phone Number_____

Signed_____
(Applicant's signature)

Date____/____/____

If a person other than the applicant has completed this form, please check one:

_____ I certify that the information provided in this application is true and correct based upon the information given to me by the applicant.

_____I certify that the information provided in this application is true and correct based upon my own knowledge of the applicant's health condition or disability.

Name_____Address_____

City _____ State _____ Zip_____

Daytime Phone_____ Relationship_____

Signature_____ Date____/____/_____

REQUEST FOR PROFESSIONAL VERIFICATION

This portion is to be completed and signed by a Physician or Healthcare Profession - Please type or print.

The applicant has signed a Release of Information on the previous page and would like to thank you for your assistance with this application. He/she is applying for ADA transportation services and the following information is needed in order to assist with a qualifying disability determination which is required in order to use the transportation system.

What is the medical diagnosis of the applicant's disability?

_____

Please describe the condition (whether physical or cognitive) which functionally prevents the applicant from using regular fixed route bus services. Be as specific as possible in your description.

_____

_____

Is the condition temporary? No____ Yes____ Expected duration:_____

If the person has a disability affecting mobility, is this person:

Able to walk 200 feet without assistance? Yes____ No____
Able to climb three 12-inch steps without assistance? Yes____ No____
Able to wait outside without support for 15 minutes? Yes____ No____

Does this person use mobility aids? If so, what kind?

_____

Is the applicant visually impaired? Explain. _____

Is there a cognitive impairment? No_____ Yes_____ If yes, can this applicant:

Give addresses and telephone numbers upon request? Yes____ No____
Recognize a destination or landmark? Yes____ No____
Ask for, understand, and follow directions? Yes____ No____

Does this person require a personal care attendant/escort to help with their mobility? Yes____ No____

Physician Name:_____ Office Address:_____
Office Phone Number_____

Signature_____ Date____/____/_____
(Physician or Healthcare Professional Signature)

Note: This application must be signed by a healthcare professional. Stamped signatures not accepted.