Greater Cleveland Regional Transit Authority
Application for ADA Paratransit Service

What is Paratransit Service?

The Americans with Disabilities Act of 1990 ensures that nondiscriminatory accessible transportation service is available for persons with disabilities. The law contains provisions for the acquisition of accessible vehicles by public and private entities, requirements for ADA complementary paratransit service by public entities operating a fixed-route transit system, and nondiscriminatory accessible transportation service.

Federal regulations define the ADA paratransit service area as being within 3/4 mile of a local fixed route when that route is in operation. If you have a disability that prevents you from using the regular fixed-route service, you may be eligible for Paratransit.

Greater Cleveland Regional Transit Authority ("GCRTA") Paratransit is a "shared-ride", origin-to-destination service available for those who, due to a functional disability or condition, are unable to use the fixed-route system. Eligibility may be unconditional, temporary, or under certain conditions.

To Apply:

1. You or your designee must fill out **PART I COMPLETELY**. Your Licensed Medical Health Professional must complete **PART II**. Please complete this application as thoroughly as possible and to the best of your ability. If there are questions that you cannot answer, or if you need assistance to complete this form, please call **ADA Registration Office at (216) 566-5124**. To be considered complete, every question on the application must be answered. If not, it will be returned to you for completion.

2. **Mail** your original application to:
   GCRTA-ADA Eligibility
   1240 West 6th Street
   Cleveland, Ohio 44113-1331

   Fax:
   216-350-5284

   Email:
   customerservice@gcrta.org

3. Once your completed application has been received, you may be scheduled for an "Eligibility & Assessment" interview. GCRTA will contact you to schedule the appointment.

4. After the completion of the "Eligibility Interview & Assessment" process, you will be notified of your ADA eligibility status within 21 calendar days; if determined eligible, you will be provided with instructions on obtaining your ADA Paratransit ID Card.

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PART I - To be completed by the applicant

PLEASE PRINT/ TYPE IN BLUE OR BLACK INK

SECTION I: Applicant Information

☐ First Time Applicant ☐ Recertification - ID#_____

Name: _____
First M.I. Last

Street Address: _____

City: _____ State: _____ Zip: _____

Day Phone: _____ Evening Phone: _____

Date of Birth: _____ / _____ / _____ Sex: ☐ Male ☐ Female

Are you a Medicaid recipient? ☐ Yes ☐ No

Are you a V.A. Disability Benefits recipient? ☐ Yes ☐ No

Are you a Medicare recipient? ☐ Yes ☐ No

Emergency Contact Person:_____

Day Phone: _____ Evening Phone: _____

Relationship to Applicant: _____

SECTION II: Current Travel Information

1. Do you currently use the fixed regular bus/rail service? ☐ Yes ☐ No

_____

_____

2. Can you get to and from the bus/rail stop nearest to your home by yourself?

   ☐ Yes ☐ No If no, explain why not?

_____

_____

3. Are there sidewalks in your neighborhood? ☐ Yes ☐ No
4. Are there sidewalks at the closest bus stop? ☐ Yes ☐ No
5. How many blocks are from your residence to the nearest bus stop?

   ☐ Less than 2 blocks ☐ 2 to 4 blocks ☐ Not sure

   ☐ 5 to 7 blocks ☐ More than 7 blocks

SECTION III: Disability and Health Condition Information

1. Why are you applying for Paratransit Services?

_____

2. What disability have you been diagnosed with?

_____

3. Does your disability prevent you from using the regular bus or rail service?

   ☐ Yes, explain below ☐ No

_____

_____

4. Is your disability considered permanent? ☐ Yes ☐ No

   If no, how long do you expect to have this disability?

   _____

5. Do you require a personal care attendant? ☐ Yes ☐ No

6. Do you currently use any mobility aids or specialized equipment? ☐ Yes ☐ No

   If yes, please select all that apply:

☐ Manual Wheelchair	☐ Oversize Wheelchair	☐ Power Wheelchair
☐ Scooter	☐ Service Animal	☐ Cane
☐ Crutches	☐ Portable Oxygen	☐ Walker
☐ White Cane	☐ Communication Board	☐ Prosthesis
☐ Brace(s)	☐ Other (please specify): _____	

SECTION IV: Applicant Certification

By signing this application, I certify that I have been truthful in answering this form and that the information that I have provided is correct to the best of my knowledge. Legal Guardians must provide documentation.

_____ _____ / _____ / _____

Applicant Signature or Legal Guardian Date

OR, if applicant is unable to sign:

_____ _____

Authorized Representative Printed Name Relationship to Applicant

_____ _____ / _____ / ____

Authorized Representative Signature Date

(Attach proof of guardianship if applicable)

PART II: MEDICAL VERIFICATION

To be completed by your licensed Physician or Psychiatrist

SECTION I: Patient Information

Patient Name_____ DOB: _____ / _____ / _____

SECTION II: Professional Information

_____

First Name Last Name Title (MD, NP, PA)

License/certification number: _____

Hospital/Agency Affiliation: _____

Address: _____

City: _____ State: _____ Zip: _____

Office phone #: _____ Fax #: _____

Medical diagnosis of disability or impairment (Do not use codes):

_____

_____

How this disability or impairment does limits one or more major life activities affecting their ability to use fixed-route bus/rail service:

_____

_____

_____

Is disability/condition permanent? • Yes • No, anticipated return date: _____ / _____ / _____

Does/Can the applicant:

Give addresses and phone numbers?	☐ Yes	☐ No	
Recognize a destination or landmark?	☐ Yes	☐ No	
Walk 200 feet without assistance	☐ Yes	☐ No	
Walk more than one (1) city block	☐ Yes	☐ No	If Yes, how many _____
Sign his/her name?	☐ Yes	☐ No	
Be left alone on a transit vehicle?	☐ Yes	☐ No	
Require a personal care assistant	☐ Yes	☐ No	
History of getting lost/wondering off	☐ Yes	☐ No	If Yes, how often _____

Does the applicant require use of a mobility device(s)? Please explain:

_____

_____

SECTION III: Certification

THIS CERTIFICATION HAS BEEN COMPLETED BY A LICENSED MEDICAL PROFESSIONAL:

I certify that the information contained in this application is true and correct to the best of my knowledge and ability. I hereby verify that the diagnosis of disability listed has been reviewed by me, is accurate and true, and represents the current physical and/or mental condition of the applicant named in this form.

Signature _____ Date: _____ / _____ / _____

For assistance completing this form, please call the
GCRTA ADA Registration Office at (216) 566-5124.