BJCTA/MAX
Paratransit Application

Return this application to:

BJCTA-MAX
Post Office Box 10212
Birmingham, Alabama 35202-0212
Email:ada@bjcta.org
Fax: (205) 521-0182

Americans with Disabilities Act

The Americans with Disabilities Act states that an eligible individual is an individual with a disability who is unable without the assistance of another individual to board, ride or disembark from any vehicle on the system which is readily accessible to and usable by individuals with disabilities.

All incomplete applications will be retuned to sender. A complete application has the following three parts completed:

1. Application
2. Medical Release
3. Medical Verification Form-This form must be completed by your medical professional/or licensed professional.

PART 1						
APPLICANT INFORMATION						
First Name		Last		M.I.	Date	
Street Address				Apartment/Unit #		
City		State		ZIP		
Phone		E-mail Address				
Date of Birth						
EMERGENCY CONTACT						
First		Last				
Street Address				Apartment/Unit #		
City		State		Zip		
Phone						
What prevents you from using our fixed route service?						

MOBILITY INFORMATION		
1. Do you use any of the following?		
☐ None	☐Crutches	☐Power Scooter
☐Support Cane	☐Picture Board	☐Portable Oxygen
☐White Cane	☐Manual Wheelchair	☐Service Animal
☐Walker	☐Power Wheelchair	☐Alphabet Board
2. Using a mobility aid, how many blocks can you travel on level ground?		
☐Less than 1	☐2 to 4	☐4 or more
3. On your own, how many blocks can you travel on level ground?		
☐Less than 1	☐2 to 4	☐4 or more
4. Do you need someone to travel with you?		
☐Yes	☐No	☐Sometimes
5. Have you had travel training or instructions on how to use public buses?		
☐Yes	☐No	
6. I learned (check all that applies)		
☐General bus travel	☐ How to ride specific routes	
7. Did you finish the training?		
☐Yes	☐No	
8. Which specific routes did you learn?		

☐If you are visually impaired please fill out the form marked "Persons with Vision Loss/Blindness".

DISABILITY OR HEALTH CONDITION				
Bone & Joint Condition				
☐None	☐Amputation			
☐Osteo-Arthritis	☐Rheumatoid Arthritis			
☐Other (Please specify)				
Neurological/Muscular				
☐None	☐Muscular Dystrophy	☐Spinal Bifida		
☐Alzheimer's	☐Parkinson's Disease	☐Post-Polio		
☐Closed Head Injury	☐Dementia	☐ Multiple Sclerosis		
☐Cerebral Palsy	☐Epilepsy/Seizures	☐ Stroke		
☐Other (Please specify)				
Heart & Circulatory Conditions				
☐None	☐Edema			
☐Congestive Heart Failure	☐Peripheral Vascular Disease			
☐Other (Please specify)				
Lung/Breathing				
☐None	☐Emphysema	☐Asthma	☐Lung/Cancer	☐COPD
☐Other (Please specify)				

Developmental/Cognitive			
☐None	☐ Autism	☐ Mood Disorder	☐ Psychosis
☐Mental Retardation (M.R.)	☐Mild Case of M.R.	☐Moderate Case of M.R.	☐Profound Case of M.R.
☐Other (Please Specify)			

Fixed Route Bus Information		
1. Do you use the public bus system?		
☐Yes	☐No	
☐How many days per week?	☐How many days per month?	
2. How do you currently travel to your frequent destination?		
☐Public Bus	☐Someone drives me	
☐Taxi	☐I drive	
3. Is the bus accessible to you?		
☐Yes	☐No	
4. Are you able to independently get to and from the nearest bus stop?		
☐Yes	☐No	
☐If no please explain		
5. How many blocks do you need to travel to get to the nearest bus stop?		
☐Less than 1	☐2 to 4	☐4 or more
6. Are you able to understand directions needed to complete a trip on the public bus?		
☐Yes	☐No	☐Sometimes
7. Are you able to get on and off lift equipped public buses?		
☐Yes	☐No	
8. Are you able to wait at least 15 minutes at a bus stop?		
☐Yes	☐No	
☐If no, please explain		
9. Are you able to grasp handles or railings, coins or tickets while boarding or exiting a public bus?		
☐Yes	☐No	
10. Are you able to identify the correct bus stop?		
☐Yes	☐No	

I certify under penalty of perjury (13a-10-101, 102, 103) that the information that I provided on this application is true and correct to the best of my knowledge. I understand that falsification of information may result in denial of service and criminal penalty. I understand the information provided on this application will be disclosed to others as necessary to provide the services I have requested and may otherwise be required by law. I understand that BJCTA may contact the person who has completed the professional verification if eligibility cannot be determined from the information in this application.

*If under 18, this page must be signed by parent or legal representative

Printed Name:	Signature/Date

*Persons acting as a representative for an applicant must certify to the above message of penalty of perjury.

Printed Name:		Signature/Date:
Relationship to Applicant:		Phone:
Address:		
City:	St:	Zip:

BJCTA/MAX
Medical Verification

This form must be completed and signed by one of the following licensed medical professionals: Physician, Clinical Social Worker, Psychiatrist, Rehabilitation Specialist, Audiologist, Ophthalmologist, Psychologist, Registered Nurse

* Altering statements made my licensed professionals will nullify the "Medical Verification Form" and subsequently the entire application will be returned

PART 3					
APPLICANT INFORMATION					
Date					
First Name		Last		M.I.	

1. Capacity in which you know the applicant

2. Please describe the applicant's impairment/condition in layman's term.

3. Please describe the impact this impairment/condition has on the applicant's ability to use the fixed route buses.

4. Is the impairment/condition permanent

☐Yes	☐No

5. If temporary, when will the applicant be able to resume normal travel?

6. Under what circumstances do the impairment/ condition flare up?

7. How far can the applicant walk without assistance? Please check one.

☐300 Feet	☐500 Feet	☐600 Feet	☐1,320 Feet

8. Does the applicant use any of these mobility devices? Please check all that apply.

☐White Cane	☐Motorized Wheel Chair	☐Crutches
☐Braces	☐Cane	☐Scooter
☐Orthopedic Cane	☐Wheelchair	☐Other:

9. How far can the applicant travel using a mobility device? Please check one.

☐300 Feet	☐500 Feet	☐600 Feet	☐1,320 Feet

10. Does the impairment/condition prevent the applicant from getting to, or from a bus stop?

☐Yes	☐No	☐Sometimes

11. If yes or sometimes please explain.

12. Does the impairment/condition prevent the applicant from waiting at a bus stop?

☐Yes	☐ No

13. How long can the applicant wait, if sitting?	Standing?	Using a mobility device?
Minutes:	Minutes:	Minutes:
14. Does the weather affect the applicant's ability to travel?		
☐Yes	☐No	☐Sometimes
15. If yes or sometimes please explain.		
16. Does the applicant have the capability to do the following? Check all that apply.		
☐Give address & phone number	☐Recognize destinations and landmark	☐Deal w/unexpected changes in routes	☐Understand and follow directions
Does the applicant require a (PCA) Personal Care Attendant when traveling by bus?		
☐Yes	☐No	

I certify that the information contained herein is true and correct to the best of my knowledge and ability.

Printed Name:	Signature/Date:	
Professional Title:	Phone:	
Name of Clinic/Agency		
Address:		
City:	St:	Zip:

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