

BJCTA/MAX

For Persons with Vision Loss/Blindness



Return this application to:

BJCTA-MAX

Post Office Box 10212
Birmingham, Alabama 35202-0212

Email:ada@bjcta.org

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.

APPLICANT INFORMATION					
First Name		Last		M.I.	Date
Street Address				Apartment/Unit #	
City		State		ZIP	
Home Phone		Work Phone			
Date of Birth					
VISION LOSS INFORMATION					
Eye Condition					
OD:		OS:			
Acuity					
OD:		<input type="checkbox"/> Stable	<input type="checkbox"/> Progressive		
OS:		<input type="checkbox"/> Stable	<input type="checkbox"/> Progressive		
Vision Loss					
<input type="checkbox"/> Total		<input type="checkbox"/> Light Perception			
<input type="checkbox"/> Severely Blurred/Distorted Vision	<input type="checkbox"/> Central Vision Field Loss	<input type="checkbox"/> Half Field Loss	<input type="checkbox"/> Night Blindness	<input type="checkbox"/> Loss of Depth Perception	
<input type="checkbox"/> Mildly Blurred/Distorted Vision	<input type="checkbox"/> Severe Glare	<input type="checkbox"/> Color Blind	<input type="checkbox"/> Tunnel Vision	<input type="checkbox"/> Other	
<input type="checkbox"/> Other-Please Specify					
Mobility Aids-Please check all that apply.					
<input type="checkbox"/> Eyeglasses	<input type="checkbox"/> Support Cane	<input type="checkbox"/> Sunglasses	<input type="checkbox"/> Magnifier	<input type="checkbox"/> Crutches	
<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Personal Care Attendant	<input type="checkbox"/> Walker	<input type="checkbox"/> White Cane	<input type="checkbox"/> Service Animal	
Mobility Training					
Has the applicant received orientation/mobility training?					
<input type="checkbox"/> Yes		<input type="checkbox"/> Yes			
By whom has the applicant received training?					
Name/Organization			Date		
Type:					

Mobility Skills of the applicant: Please check all that apply.

<input type="checkbox"/> Manage steps and curbs independently	<input type="checkbox"/> Distinguish walk/don't walk signs	<input type="checkbox"/> Distinguish red, yellow & green
<input type="checkbox"/> Read street signs	<input type="checkbox"/> Cross intersections independently	<input type="checkbox"/> Find their way with directions

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.

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 by licensed professionals will nullify the "Medical Verification Form" and subsequently the entire application will be returned

APPLICANT INFORMATION					
Date					
First Name		Last		M.I.	
MEDICAL PROFESSIONAL INFORMATION					
Name:			Signature/Date:		
Professional Title:			Phone:		
Name of Clinic/Agency					
Address:					
City:		St:		Zip:	

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