"Improve, Impact, Ignite"
Birmingham Jefferson County Transit Authority
1801 Morris Avenue
Birmingham, Alabama 35203

Applicant for Paratransit Service:

The information in this application is needed to establish your eligibility for Paratransit service under the Americans with Disability Act (ADA). The ADA requires that comparable transportation be provided to persons with functional disabilities who, because of their disability, are unable to access or use regular bus service. If you believe that you have a disability that prevents you from using a BJCTA/MAX Transit bus, please complete the enclosed application and return it to the Birmingham Jefferson County Transit Authority as indicated on the application.

A complete application has the following three parts:

1. Application (The Application should be completed and signed by the applicant, or their representative.)
2. Release of Information Form (The Release of Information form should be completed and signed by the applicant, or their representative.)
3. Medical Verification (The Medical Verification should be completed and signed by one of the licensed medical professionals indicated on the verification form.)

In order for the BJCTA to evaluate your application for Paratransit eligibility, it may be necessary for the BJCTA to contact a physician or other licensed health care professionals to confirm the information you have provided. It is important that all parts of this form are completed and returned promptly. If the application is not complete, it will be returned to you for completion, which will delay the determination process. It could also delay your transportation. A determination regarding your eligibility for Paratransit service will be made within 21 days after receipt of the completed application. You will be notified in writing as to the decision on eligibility.

If eligibility is denied, the written notification of denial of services will also include information as to how you may appeal the decision.

If you have any questions, or if you need help in completing this application, please call BJCTA Paratransit at (205) 521-9048 or (205) 521-0180.

BJCTA does not collect fares for travel to and from Paratransit eligibility assessments, interviews, or photo ID issuance. These services are provided at no cost to the rider.

BJCTA/MAX
Paratransit Application

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.

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
☐Intellectual Disability (I.D.)	☐Mild Case of I.D.	☐Moderate Case of I.D.	☐Profound Case of I.D.
☐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
Release of Information Form

Return this application to:

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Post Office Box 10212
Birmingham, Alabama 35202-0212
Email:ada@bjcta.org

PART 2							
APPLICANT INFORMATION							
First Name		Last		M.I.	Date		
Address		Apartment/Unit #					
City		State		ZIP			
Phone		E-mail Address					
Applicant's Signature							
PERSONS TO CONTACT FOR INFORMATION							
Professional Title							
First		Last					
Street Address				Apartment/Unit #			
City		State		Zip			
Phone		Fax					
Professional Title							
First		Last					
Street Address				Apartment/Unit #			
City		State		Zip			
Phone		Fax					
Professional Title							
First		Last					
Street Address				Apartment/Unit #			
City		State		Zip			
Phone		Fax					

I authorize my physician, case manager, doctor, professional, mobility trainer, neurologist, etc. (listed above) to discuss my diagnosis, treatment plan, prognosis for the purpose of determining my ability to use regular public transit buses, trolleys, trains, etc., that are accessible to and usable by individuals with disabilities. I understand that an in person interview may be necessary to complete the apapplication process.

In order to fully understand the functional limitations of your disability, MAX or its agents may need to speak to your case manager, doctor, professional, mobility trainer, neurologist, etc. After reading this release, please sign it, and list the names, addresses, phone, and fax numbers of the professionals most familiar with your functional abilities. (Please note: This authorization is good for one year only. If your condition changes after that time, a new "release" will have to be submitted.)

For office use only-Do not write in this box.					
Approval/Denial Date		Expiration Date			
Disability			Mobility Device		
Restrictions					
Personal Care Attendant Required?	☐Yes			☐No	
Out of Service Area?	☐Yes			☐No	
ADA Service Area	☐Yes			☐No	
Dialysis & Medical only					
Chemo/Radiation only					
Temporary with conditions					
Temporary with no conditions					
Comments:					
Certification#					

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.

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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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