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:			☐ Stable		☐ Progressive				
OS:			☐ Stable		☐ Progressive				
Vision Loss									
☐ Total			☐ Light Perception						
☐ Severely Blurred/Distorted Vision	☐ Central Vision Field Loss	☐ Half Field Loss	☐ Night Blindness	☐ Loss of Depth Perception					
☐ Mildly Blurred/Distorted Vision	☐ Severe Glare	☐ Color Blind	☐ Tunnel Vision	☐ Other					
☐ Other-Please Specify									
Mobility Aids-Please check all that apply.									
☐ Eyeglasses	☐ Support Cane	☐ Sunglasses	☐ Magnifier	☐ Crutches					
☐ Wheelchair	☐ Personal Care Attendant	☐ Walker	☐ White Cane	☐ Service Animal					
Mobility Training									
Has the applicant received orientation/mobility training?									
☐ Yes			☐ Yes						
By whom has the applicant received training?									
Name/Organization			Date						
Type:									

Mobility Skills of the applicant: Please check all that apply.		
☐ Manage steps and curbs independently	☐ Distinguish walk/don't walk signs	☐ Distinguish red, yellow & green
☐ Read street signs	☐ Cross intersections independently	☐ 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 my 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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