



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 returned 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	Apartment/Unit #
Street Address		Zip
City	State	
Phone		

What prevents you from using our fixed route service?

MOBILITY INFORMATION

1. Do you use any of the following?

<input type="checkbox"/> None	<input type="checkbox"/> Crutches	<input type="checkbox"/> Power Scooter
<input type="checkbox"/> Support Cane	<input type="checkbox"/> Picture Board	<input type="checkbox"/> Portable Oxygen
<input type="checkbox"/> White Cane	<input type="checkbox"/> Manual Wheelchair	<input type="checkbox"/> Service Animal
<input type="checkbox"/> Walker	<input type="checkbox"/> Power Wheelchair	<input type="checkbox"/> Alphabet Board

2. Using a mobility aid, how many blocks can you travel on level ground?

<input type="checkbox"/> Less than 1	<input type="checkbox"/> 2 to 4	<input type="checkbox"/> 4 or more
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3. On your own, how many blocks can you travel on level ground?

<input type="checkbox"/> Less than 1	<input type="checkbox"/> 2 to 4	<input type="checkbox"/> 4 or more
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4. Do you need someone to travel with you?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
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5. Have you had travel training or instructions on how to use public buses?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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6. I learned (check all that applies)

<input type="checkbox"/> General bus travel	<input type="checkbox"/> How to ride specific routes
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7. Did you finish the training?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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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**

<input type="checkbox"/> None	<input type="checkbox"/> Amputation
<input type="checkbox"/> Osteo-Arthritis	<input type="checkbox"/> Rheumatoid Arthritis

 Other (Please specify)**Neurological/Muscular**

<input type="checkbox"/> None	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Spinal Bifida
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Post-Polio
<input type="checkbox"/> Closed Head Injury	<input type="checkbox"/> Dementia	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Stroke

 Other (Please specify)**Heart & Circulatory Conditions**

<input type="checkbox"/> None	<input type="checkbox"/> Edema
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Peripheral Vascular Disease

 Other (Please specify)**Lung/Breathing**

<input type="checkbox"/> None	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Asthma	<input type="checkbox"/> Lung/Cancer	<input type="checkbox"/> COPD
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 Other (Please specify)

Developmental/Cognitive			
<input type="checkbox"/> None	<input type="checkbox"/> Autism	<input type="checkbox"/> Mood Disorder	<input type="checkbox"/> Psychosis
<input type="checkbox"/> Intellectual Disability (I.D.)	<input type="checkbox"/> Mild Case of I.D.	<input type="checkbox"/> Moderate Case of I.D.	<input type="checkbox"/> Profound Case of I.D.
<input type="checkbox"/> Other (Please Specify)			

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



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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 application 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?	<input type="checkbox"/> Yes		<input type="checkbox"/> No
Out of Service Area?	<input type="checkbox"/> Yes		<input type="checkbox"/> No
ADA Service Area	<input type="checkbox"/> Yes		<input type="checkbox"/> No
Dialysis & Medical only			
Chemo/Radiation only			
Temporary with conditions			
Temporary with no conditions			
Comments:			
Certification#			

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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

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