



Birmingham-Jefferson County Transit Authority
1801 Morris Ave
Birmingham, AL 35203

Applicant for Paratransit Service:

The information in this application is required to establish your eligibility for Paratransit Service under the American with Disability Act (ADA). The ADA requires that comparable transportation be provided to persons with functional disability 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 (BJCTA) as indicated on the application.

A complete application has the following three (3) parts:

1. Application (The application should be completed and signed by the applicant or their representative).
2. Release of Information (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 BJCTA to evaluate your application for Paratransit eligibility, it may be necessary for BJCTA to contact a physician or other licensed health care professionals to confirm the information you 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 our 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 regarding eligibility.

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

If you have any questions, or if you need help completing this application, please call BJCTA Paratransit at 205-521-0180 or the ADA office at 205-961-5614.

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

Mobility Information

BJCTA/MAX Transit
Paratransit Application

Return this application to:

BJCTA/MAX Transit
Post Office Box 10212
Birmingham, Alabama 35202
Email: ada@bjcta.org

Americans with Disability Act

The Americans with Disability 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 disability.

All incomplete applications will be returned to sender. A complete application has the following three (3) parts completed:

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

Part 1

Applicant Information

First Name	Last Name	M.I.	Date
Street Address			Apartment/Unit #
City	State	Zip	
Phone	Email		
Date of Birth (DD/MM/YYYY)			

Emergency Contact

First Name	Last Name	M.I.	Date
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?

- | | | |
|---------------------------------------|--|--|
| <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 |
|--------------------------------------|---------------------------------|------------------------------------|

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 |
|--------------------------------------|---------------------------------|------------------------------------|

4. Do you need someone to travel with you?

- | | | |
|------------------------------|-----------------------------|------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
|------------------------------|-----------------------------|------------------------------------|

5. Have you had travel training or instructions on how to use public bus?

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

6. I Learned (check all that applies)

- | | |
|---|---|
| <input type="checkbox"/> General bus travel | <input type="checkbox"/> How to ride a specific route |
|---|---|

7. Did you finish the training?

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

8. Which specific route did you learn?

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

Disability or Health Conditions

Bone and Joint Conditions

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Amputation |
| <input type="checkbox"/> Osteo-Arthritis | <input type="checkbox"/> Rheumatoid |
| <input type="checkbox"/> 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"/> Demetia | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> 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 |
|-------------------------------|--------------------------------|---|--|

Lung /Breathing

- None Emphysema Asthma Lung/Cancer COPD
 Other (Please specify)

Developmental/Cognitive

- None Autism Mood Disorder Psychosis
 Intellectual Disability I.D. Mild Case 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 bus?

- Yes No

8. Are you able to wait at least 15 minutes at a bus stop?

- Yes No If no, explain

9. Are you able 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 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 his 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

Print 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.

Print Name:	Signature/Date	
Relations to Applicant:	Phone:	
Address:		
City:	State:	Zip:



BJCTA/MAX

Release of Information Form

Return this application to:

BJCTA-MAX
Post Office Box 10212
Birmingham, Al 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 Signature:

Persons To Contact for Information

Professional Title
First Name, Last, Street Address, Apartment/Unit #, City, State, Zip, Phone, Fax

Professional Title
First Name, Last, Street Address, Apartment/Unit #, City, State, Zip, Phone, Fax

Professional Title
First Name, Last, Street Address, Apartment/Unit #, City, State, Zip, Phone, Fax

I authorize my physician, case manager, doctor, professional, mobility trainer, etc. (listed above) to discuss my diagnosis, treatment plan, prognosis for the purpose of determining my ability to use the regular public transit buses, trolleys, trains etc., that are accessible to usable by individuals with disabilities. I understand that 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 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.)



**BJCTA/MAX Transit
Medical Verification**

Return this application to:

BJCTA/MAX Transit
Post Office Box 10212
Birmingham, Alabama 35202
Email: ada@bjcta.org

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

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

**Part 3
Application Information**

First Name	Last Name	M.I.	Date
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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If temporary, when will the applicant be able to resume normal travel?			
5. Under what circumstances do the impairment/condition flare up?			

<p>6. How far can the applicant walk without assistance? Please check one.</p> <p><input type="checkbox"/> 300 Feet</p> <p><input type="checkbox"/> 500 Feet</p> <p><input type="checkbox"/> 600 Feet</p> <p><input type="checkbox"/> 1320 Feet</p>
<p>7. Does the applicant use any of these mobility devices? Check all that apply.</p> <p><input type="checkbox"/> White Cane</p> <p><input type="checkbox"/> Braces</p> <p><input type="checkbox"/> Cane</p> <p><input type="checkbox"/> Crutches</p> <p><input type="checkbox"/> Motorized Wheelchair</p> <p><input type="checkbox"/> Orthopedic Cane</p> <p><input type="checkbox"/> Wheelchair</p> <p><input type="checkbox"/> Scooter</p> <p><input type="checkbox"/> Other:</p>
<p>8. How far can the applicant travel using a mobility device? Please check one.</p> <p><input type="checkbox"/> 300 Feet</p> <p><input type="checkbox"/> 500 Feet</p> <p><input type="checkbox"/> 600 Feet</p> <p><input type="checkbox"/> 1320 Feet</p>
<p>9. Does the impairment/condition prevent the applicant from getting to, or from the bus stop?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Sometimes</p> <p>If yes or sometimes, please explain.</p>
<p>10. Does the impairment/condition prevent the applicant from waiting at a bus stop?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
<p>11. How long can the applicant wait if sitting (minutes)?</p> <p>12. How long can the wait if standing (minutes)?</p> <p>13. How long can the applicant wait if using a mobility device (minutes)?</p>
<p>14. Does the weather affect the applicant ability to travel?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Sometimes</p> <p>If yes or sometimes, please explain.</p>

15. Does the applicant have the capability to do the following? Check all that apply?

- Give address and phone number
- Recognize destination and landmarks
- Deal with unexpected changes in routes
- Understand and follow direction

16. Does the applicant require a Person Care Attendant (PCA) 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.

Print Name: _____ Signature/Date _____

Professional Title: _____ Phone: _____

Name of Clinic/Agency: _____

Address: _____

City/State/Zip: _____

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