


ERIE METROPOLITAN TRANSIT AUTHORITY


127 E. 14TH STREET

ERIE, PA 16503

Tel: (814) 455-3330

TDD: 1 (800)-323-5579

Fax: (814) 455-3530

REQUEST FOR CERTIFICATION OF AMERICANS WITH DISABILITIES ACT (ADA)

Please be sure to complete all sections in the application.
An incomplete application will lead to a delay in our ability to serve you.

Last Name: _____ First Name: _____
 Street Address: _____ Apt #/Building # _____
 City/Town: _____ State: _____ Zip: _____
 If this is a Licensed Nursing Care Facility, name of facility: _____
 Daytime Telephone _____ Evening Telephone _____
 TDD/Relay # (if applicable) _____ Date of Birth ____/____/____
 Do you need information given in another format? ☐ YES ☐ NO
 If yes, which format? ☐ larger type ☐ braille ☐ audio ☐ other: _____
 Employer or Program Site (if any): _____
 Contact Person: _____ Telephone: _____

In case of an emergency or if we are unable to reach you at your regular number(s), please let us know who to contact below:

Last Name: _____ First Name: _____
 Daytime Telephone _____ Evening Telephone _____
 Relationship: _____ Agency (if applicable) _____

If someone assisted you with this application, that person must complete the following: Last

Name: _____ First Name: _____
 Street Address: _____ Apt #/Building # _____
 City/Town: _____ State: _____ Zip: _____
 Daytime Telephone _____ Evening Telephone _____
 Relationship: _____ Agency (if applicable) _____
 Signature: _____ Today's Date ____/____/____

ADA ELIGIBILITY CERTIFICATION REQUEST

The information obtained through this certification process will only be used by the Erie Metropolitan Transit Authority to determine your eligibility for its special transportation services. Upon your request, information will only be shared with other transit providers to assist your travel in other communities. The information will not be provided to any other person or agency.

The Erie Metropolitan Transit Authority is an affirmative action employer and service provider. We do not discriminate with regard to race, color, creed, religion, national origin, age, ethnic background, sex, sexual orientation or disability.

ADA DEFINITION OF DISABILITY

The following persons with disabilities are eligible for the ADA door-to-door services:

1. Any person with a disability who is unable, as a result of a physical or mental impairment, and without the assistance of another individual (except the operator of a wheelchair lift) to board, ride or disembark from any public bus.
2. Any person with a disability who has a specific impairment-related condition which prevents them from traveling to or from a bus stop on the public bus system.
3. Architectural and environmental barriers such as distance, terrain or weather, do not, standing alone, form a basis for eligibility. However, a person may be eligible if the interaction of the disability and barriers prevent the person from traveling to or from the public bus stop.

PARATRANSIT V.S. FIXED ROUTE ELIGIBLE

For many customers' persons with disabilities, in many circumstances, getting to a bus stop is possible. If an impairment-related condition only makes the job of accessing transit more difficult than it might otherwise be, but does not prevent the travel, then the person is not eligible.

Any person who does not meet the three requirements listed above, will be advised to apply for EMTA's Reduced Fare Program. Under this program, customers ride for 1/2 the full fare on EMTA's handicap accessible buses.

For more information on EMTA's Reduced Fare Program, please call 814-452-3515.

INFORMATION ABOUT YOUR PUBLIC BUS EXPERIENCE

Do you ride the public bus? ☐ YES ☐ NO ☐ SOMETIMES

When was the last time you used the public bus service? _____

I can use the public bus with little or no difficulty.

☐ ALWAYS ☐ SOMETIMES ☐ NEVER

I can never get to the public bus stop by myself due to the severity of my disability.

☐ YES ☐ NO

I have a temporary disability that prevents me from using the public bus. I will need door-to-door services only until I recover.

☐ YES ☐ NO

I have a disability that prevents me from remembering and understanding all I have to do to use the public bus. I may be able to learn with training.

☐ YES ☐ NO

I have a visual disability that prevents me from getting to and from the public bus stop.

☐ YES ☐ NO

I cannot use the public bus for some trips because I have not learned the route, or there are some other barriers that prevent me from using the public bus.

☐ YES ☐ NO

INFORMATION ABOUT FREE TRAVEL TRAINING

I could use the public buses if I had general knowledge about routes and times.

☐ YES ☐ NO

Travel Training is a free service which teaches people with disabilities how to ride and use the public bus service. Would you like more information?

☐ YES ☐ NO

INFORMATION ABOUT YOUR FUNCTIONAL ABILITY

For each statement, check one answer. Your answer should be based on how you feel most of the time under normal circumstances, and whether you can perform this activity.

I can cross the street if there are curb cuts.

☐ ALWAYS ☐ SOMETIMES ☐ NEVER

I can travel up/down a gradual hill in good weather conditions.

☐ ALWAYS ☐ SOMETIMES ☐ NEVER

I can find my way to the public bus stop if someone shows me once.

☐ ALWAYS ☐ SOMETIMES ☐ NEVER

I am able to wait for 10 minutes using my mobility aid (if applicable) at a public bus stop that does not have seats and a shelter.

☐ ALWAYS ☐ SOMETIMES ☐ NEVER

I am able to ask for, understand, and follow directions.

☐ ALWAYS ☐ SOMETIMES ☐ NEVER

I am able to detect curbs, ramps, and other drop off areas.

☐ ALWAYS ☐ SOMETIMES ☐ NEVER

Is there any medication that affects your daily travel? ☐ YES ☐ NO

Are there any other effects of your disability of which we need to be aware (sensitivity to cold, disorientation, chronic fatigue, etc.)?

Answer the following questions by checking all that apply.

What barriers would make it difficult for you to use the public bus from your home to your destination(s)?

☐ Busy streets I must cross ☐ No Sidewalks ☐ Steep Hills
☐ Sidewalks in poor condition ☐ No Curb Cuts ☐ No crosswalks at street corners

Other _____

Can you get on and off a public bus?

☐ Yes, I can use the lift and/or ramp
☐ I probably could with instruction
☐ No (Please explain)

INFORMATION ABOUT YOUR DISABILITY

The following information will be used to assure the use of an appropriate vehicle and the proper assistance when you request transportation from the Erie Metropolitan Transit Authority . It will also permit us to conduct an analysis of each trip request.

What type of disability prevents you from using public bus service? Check all that apply:

☐ Physical ☐ Visual ☐ Cognitive ☐ Mental Health ☐ Hearing ☐ Other Identify

Disability by Name(s) _____

Please describe your disability in detail _____

Is this condition temporary? ☐ YES ☐ NO If Yes, how long? _____

Will you use any of the following aids for mobility? (Check all that apply)

☐ Manual Wheelchair ☐ Powered Scooter ☐ Cane ☐ Service Animal
☐ Electric Wheelchair ☐ Oxygen Tank ☐ Walker ☐ Braces
☐ Oversized Wheelchair ☐ Crutches ☐ Cart ☐ Communication Board
☐ Other _____

Do you require the assistance of a personal care attendant? ☐ YES ☐ NO ☐ SOMETIMES

Can you travel without the assistance of another person? ☐ YES ☐ NO ☐ SOMETIMES

If Yes, how far? _____

Using only your mobility aid (if any) can you wait outside without support?

If Yes, how long? _____

APPLICANT'S CERTIFICATION

I understand that the purpose of this application is to determine if there are times when I cannot use the public buses and must therefore use paratransit (eLift) services. I understand that any information about my disability or age contained in this application will be kept confidential and shared only with professionals involved in providing this service. I certify that, to the best of my knowledge, the information in this application is true and correct. I understand that providing false or misleading information may result in the Erie Metropolitan Transit Authority re-evaluating my eligibility.

Signature of Applicant or Guardian

_____/_____/_____
Date

PHYSICIAN OR OTHER PROFESSIONAL VERIFICATION FORM

To be completed by one of the following licensed/ qualified professionals;Chiropractor, Physician, Physician assistant, Registered Nurse, Registered Occupational Therapist, Registered Physical Therapist, Respiratory Care, Ophthalmologist, Speech Pathologist, Vocational Rehabilitation Councilor, Licensed Psychologist, Licensed Social Worker, Mental Health Counselor, Nurse Practitioner, Orientation/Mobility Specialist

1. What type of disability prevents applicant from using public bus service? Check all that apply:

☐ Physical ☐ Visual ☐ Cognitive ☐ Mental Heath ☐ Hearing ☐ Other

2. Identify Disability by Name(s) DSM-IV _____

3. Date of onset? _____

4. What is the prognosis? _____

5. Is this person taking psychotropic, antidepressant, or other medication?If

yes, answer a, b, c, and d:

a. Did you prescribe this medication? ☐YES ☐NO

b. List medication(s) individual is currently using?

Name of Medication	Dosage/Frequency	Date Prescribed
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

c. Do you deem individual to be compliant in taking medication? ☐YES ☐NO

d. How does above medication affect individual's functional ability to travel independently on a EMTA bus? (drowsiness, confusion etc.)

PHYSICIAN OR OTHER PROFESSIONAL VERIFICATION FORM

6. Has the individual's functional ability changed temporarily due to adjustment to medication?

☐YES

☐NO

If yes, please explain and give expected duration:

7. When taking medication compliantly, will the individual be able to travel independently on a bus in the community?

☐YES

☐NO

8. Does the individual drive?

☐YES

☐NO

9. Does the individual currently experience either auditory or visual hallucinations?

☐YES

☐NO

If yes, would s/he be likely to experience auditory or visual misperceptions due to hallucinations?

☐YES

☐NO

10. Is this individual's disability the same everyday?

☐YES

☐NO

a. What is a 'good' day like? _____

b. What is the individual able to do on a 'good' day? _____

c. What is a 'bad' day like? _____

d. How many 'good/bad' days has the individual had in the last month? _____

e. Does anything trigger a 'bad' day? ____Yes ____No, Explain _____

PHYSICIAN OR OTHER PROFESSIONAL VERIFICATION FORM

11. Are any of the following affected by individual's disability? Check ALL that apply:

- | | |
|--|--|
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Monitoring Time |
| <input type="checkbox"/> Problem Solving | <input type="checkbox"/> Judgement |
| <input type="checkbox"/> Short Term Memory | <input type="checkbox"/> Communication |
| <input type="checkbox"/> Long Term Memory | <input type="checkbox"/> Inconsistent Performance |
| <input type="checkbox"/> Concentration | <input type="checkbox"/> Coping Skills |
| <input type="checkbox"/> Gait or Balance | <input type="checkbox"/> Inappropriate Social Behavior |
| <input type="checkbox"/> Other _____ | (aggressive, sexual, overly-friendly) |

Please explain how the above affects the individual to safely travel:

12. Does this individual demonstrate inappropriate social behavior? ☐ YES ☐ NO

If yes, please explain.

13. Describe how the individual's disability affects his/her ability to complete the following travel tasks:

Traveling alone outside _____

Leaving the house on time _____

Seeking and acting on directions _____

Finding way to and from bus stop _____

Crossing streets _____

Waiting for a bus _____

Boarding the correct bus _____

Riding on the bus _____

Transferring to a second bus or exiting at the correct destination _____

Monitoring time _____

PHYSICIAN OR OTHER PROFESSIONAL VERIFICATION

14. Would EMTA bus travel training (learn how to ride, read schedules, boarding instructions) allow the individual to travel independently under all circumstances on EMTA's bus system?

☐ YES ☐ NO

If no, the why? _____

15. How will using the eLIFT better suit this individual than using the EMTA bus system?

16. Are there any other life skills that this individual lacks that would be an indication of his/her inability to use public transportation?

17. Is there any additional information regarding this individual which you believe impacts his/her functional ability to use EMTA fixed route service or any special circumstance which you believe should be considered?

PHYSICIAN OR OTHER PROFFESIONAL CERTIFICATION

I have reviewed all of the information contained in this application and hereby certify that all the information is true and correct to the best of my knowledge and ability. I certify that the applicant named, _____, is under my professional care. I hereby swear and affirm that the information I provided is true and correct.

Name: _____

Agency: _____

Office Address: _____

City/Town: _____ State: _____ Zip: _____

Office Phone: _____ Office Fax: _____

Signature: _____ Date: ____/____/____

EMTA will determine eligibility within 21 days of receipt of the completed application. If approved, the applicant will be notified in writing and eligibility will be granted for a period of 5 years. When eligibility expires, there is a recertification process to keep eligibility current. If your application is not approved, a determination letter will be sent that will include the reason for ineligibility and advise you of the procedures to follow if you wish to appeal. If EMTA does not make a determination within 21 days, the applicant will be granted temporary eligibility and allowed to ride paratransit service until such time as a determination is made, this includes a written decision. Please note, the submission of this application does not guarantee eligibility.