HANDIVAN APPLICATION (PART 1)

REQUEST FOR CERTIFICATION OR RE-CERTIFICATION OF ADA PARATRANSIT ELIGIBILITY

Application (Part 1) should be completed by the applicant. Application (Part 2) should be completed by a physician, healthcare or rehabilitation professional. The information obtained in the certification process will only be used by the City of Danville for the provision of transportation services. It will only be shared with other transit providers to facilitate travel in those areas and will not be provided to any other person or agency.

NAME:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ WORK PHONE:_____

CELL PHONE:_____ DATE OF BIRTH: _____/_____/_____

WHAT IS THE DISABILITY WHICH PREVENTS YOU FROM USING OUR FIXED ROUTE BUS SERVICE? ***PLEASE CHECK ALL THAT APPLY***:

PHYSICAL _____ COGNITIVE _____ MENTAL _____ OTHER _____

IS THIS CONDITION TEMPORARY? YES_____ NO_____

IF TEMPORARY, EXPECTED DURATION UNTIL _____/_____/_____

HOW DOES THIS DISABILITY PREVENT YOU FROM USING THE FIXED ROUTE BUS SERVICE? PLEASE EXPLAIN COMPLETELY. USE AN ADDITIONAL SHEET IF NEEDED.

_____

_____

_____

IN ORDER TO BETTER SERVE YOU, IS THERE ADDITIONAL INFORMATION REGARDING YOUR DISABILITY WE NEED TO KNOW?

_____

_____

_____

THE FOLLOWING INFORMATION WILL BE USED TO GUARANTEE THAT A PROPER VEHICLE IS UTILIZED TO PROVIDE YOUR TRANSPORTATION.

DO YOU USE ANY OF THE FOLLOWING AIDS FOR MOBILITY?

YES _____ NO _____ **(IF YES, CHECK ALL THAT APPLY)**

MANUAL WHEELCHAIR _____ ELECTRIC WHEELCHAIR _____
POWERED SCOOTER _____ CANE _____ CRUTCHES _____
WALKER _____ GUIDE DOG _____ LEG BRACES _____
OTHER (PLEASE SPECIFY)_____

DO YOU REQUIRE A PERSONAL CARE ATTENDANT WHEN YOU TRAVEL?

(THERE IS NO CHARGE FOR A REQUIRED PERSONAL CARE ATTENDANT.)

YES _____ NO _____

CAN YOU TRAVEL 200 FEET WITHOUT THE ASSISTANCE OF ANOTHER PERSON?

YES _____ NO _____ SOMETIMES _____ PLEASE EXPLAIN:

_____

CAN YOU TRAVEL 1/4 MILE WITHOUT THE ASSISTANCE OF ANOTHER PERSON?

YES _____ NO _____ SOMETIMES _____ PLEASE EXPLAIN:

_____

CAN YOU CLIMB THREE 12-INCH STEPS WITHOUT ASSISTANCE?

YES _____ NO _____ SOMETIMES _____ PLEASE EXPLAIN:

_____

CAN YOU WAIT OUTSIDE WITHOUT SUPPORT FOR TEN MINUTES?

YES _____ NO _____ SOMETIMES _____ PLEASE EXPLAIN:

_____

PERSON TO BE CONTACTED IN THE EVENT OF AN EMERGENCY:

NAME:_____ PHONE NUMBER:_____
ADDRESS: _____

I HEREBY CERTIFY THAT THE INFORMATION PROVIDED IN THIS APPLICATION IS CORRECT.

SIGNATURE:_____ DATE: _____

IF THIS APPLICATION HAS BEEN COMPLETED BY SOMEONE OTHER THAN THE PERSON REQUESTING THE CERTIFICATION OR RE-CERTIFICATION, THAT PERSON MUST COMPLETE THE FOLLOWING:

NAME: _____ ADDRESS:_____
CITY:_____ STATE:_____ ZIP:_____
DAYTIME PHONE NUMBER:_____

SIGNATURE:_____ DATE: _____

HANDIVAN APPLICATION (PART 2)

REQUEST FOR PROFESSIONAL VERIFICATION FOR CERTIFICATION OR RE-CERTIFICATION OF ADA PARATRANSIT ELIGIBILITY

APPLICATION (PART 2) MUST BE COMPLETED BY A QUALIFIED PHYSICIAN, OR A HEALTH CARE OR REHABILITATION PROFESSIONAL.

PHYSICIAN'S NAME:_____

PATIENT'S NAME:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

DATE OF BIRTH: _____/_____/_____

CAPACITY IN WHICH YOU KNOW THE APPLICANT:

_____

DIAGNOSIS OF CONDITION CAUSING DISABILITY:

_____

IS THIS TEMPORARY: YES _____ NO _____

IF TEMPORARY, EXPECTED DURATION UNTIL _____/_____/_____

IS THIS PERSON ABLE TO:

TRAVEL 200 FEET WITHOUT THE ASSISTANCE OF ANOTHER PERSON?

YES _____ NO _____ SOMETIMES _____ PLEASE EXPLAIN:

_____

TRAVEL 1/4 MILE WITHOUT THE ASSISTANCE OF ANOTHER PERSON?

YES _____ NO _____ SOMETIMES _____ PLEASE EXPLAIN:

_____

CLIMB THREE 12-INCH STEPS WITHOUT ASSISTANCE?

YES _____ NO _____ SOMETIMES _____ PLEASE EXPLAIN:

_____

WAIT OUTSIDE WITHOUT SUPPORT FOR TEN MINUTES?

YES _____ NO _____ SOMETIMES _____ PLEASE EXPLAIN:

_____

DOES THIS PERSON USE ANY OF THE FOLLOWING AIDS FOR MOBILITY?
PLEASE CHECK ALL THAT APPLY.

MANUAL WHEELCHAIR _____ ELECTRIC WHEELCHAIR _____
POWERED SCOOTER _____ CANE _____ CRUTCHES _____
WALKER _____ GUIDE DOG _____ LEG BRACES _____
OTHER (PLEASE SPECIFY)_____

DOES THIS PERSON REQUIRE A PERSONAL CARE ATTENDANT TO TRAVEL WHEN USING TRANSIT? *(THERE IS NO CHARGE FOR A REQUIRED PERSONAL CARE ATTENDANT.)*

YES _____ NO _____

DOES THIS PERSON HAVE A VISUAL IMPAIRMENT? YES _____ NO _____

IF THE PERSON HAS A VISUAL IMPAIRMENT, PLEASE IDENTIFY:

VISUAL ACUITY WITH BEST CORRECTION:

RIGHT EYE _____ LEFT EYE _____ BOTH EYES _____

VISUAL FIELDS:

RIGHT EYE _____ LEFT EYE _____ BOTH EYES _____

HOW DOES THIS DISABILITY PREVENT THE PERSON FROM USING THE FIXED ROUTE BUS SERVICE? PLEASE EXPLAIN COMPLETELY. USE AN ADDITIONAL SHEET IF NEEDED.

_____

_____

IS THIS PERSON ABLE TO:

APPLY THE TIME OF DAY TO A SERVICE SCHEDULE? YES _____ NO_____

GIVE ADDRESSES AND TELEPHONE NUMBERS UPON REQUEST? YES _____ NO_____

RECOGNIZE A DESTINATION OR LANDMARK? YES _____ NO_____

ASK FOR, UNDERSTAND AND FOLLOW DIRECTION? YES _____ NO_____

SAFELY AND EFFECTIVELY TRAVEL THROUGH UNFAMILIAR SURROUNDINGS?

YES _____ NO_____

SAFELY AND EFFECTIVELY TRAVEL THROUGH CROWDED FACILITIES?

YES _____ NO_____

DEAL WITH UNEXPECTED SITUATIONS OR UNEXPECTED CHANGE IN ROUTINE?

YES _____ NO_____

BOARD, DE-BOARD, AND NAVIGATE THE FIXED ROUTE BUS SERVICE UNDER CERTAIN CONDITIONS BUT NOT ALWAYS? YES _____ NO_____

HOW DOES THIS DISABILITY PREVENT THE PERSON FROM USING THE FIXED ROUTE BUS SERVICE? PLEASE EXPLAIN COMPLETELY. USE AN ADDITIONAL SHEET IF NEEDED.

_____

_____

YOUR NAME/TITLE:_____

OFFICE/AGENCY ADDRESS:_____

OFFICE PHONE NUMBER:_____

SIGNATURE:_____ DATE: _____

PLEASE RETURN TO: **DANVILLE TRANSIT - P.O. BOX 3300 - DANVILLE, VIRGINIA 24543**