CATA
3R Pond Rd
Gloucester, MA
01930

Dial-A-Ride and ADA Paratransit Eligibility Application Form

CATA use only:
ID # _____
Date_____

- - - PLEASE PRINT - - -

PART A
(This part must be completed by all applicants)

First Name_____ Middle Initial_____

Last Name_____

Street Address_____ Apt #_____

Mailing Address (if different)_____

City_____ State_____ Zip_____

Phone (daytime)_____ (evening)_____

Date of Birth (month/day/year)_____ Sex(M/F)_____

Please give us the name and phone number of a friend or relative we can call in case we are unable to reach you at your regular number:

Name_____

Relationship_____ Phone #_____

Do you have a disability or health condition that prevents you from sometimes using CATA fixed route buses?

❒ **NO, I am applying based only on my age (60 or older).** ATTACH A COPY OF DOCUMENTATION OF YOUR AGE (government ID). STOP HERE. You do not need to complete PARTS B and C below. Return this form to CATA at the address shown above to become eligible for Dial-A-Ride service.

❒ **YES, I am applying for "ADA Paratransit Eligibility."** Complete PARTS B and C below.

PART B

This part only needs to be completed if you have a disability or health condition that prevents you from sometimes or always using CATA's fixed route bus service. Persons completing this section will be considered for "ADA Paratransit Eligibility." Information about disability or health condition will be kept strictly confidential.

1. What is the disability or health condition that prevents you from using CATA fixed route buses? Please describe all disabilities or health conditions that affect your travel.

_____

_____

_____

2. How does this disability or health condition prevent you from using CATA fixed route service? Please explain completely. Use additional sheets if needed.

_____

_____

_____

_____

_____

4. Do you use any of the following mobility aids? (Check all that apply)

❒ Manual Wheelchair ❒ Electric Wheelchair ❒ Powered Scooter

❒ Cane ❒ Walker ❒ Crutches ❒ Braces

❒ Service Animal (describe): _____

❒ Other (describe): _____

❒ No, I do not use any mobility aids

5. Do you ever need to bring someone else with you to help you when you travel (a "personal assistant" or "personal attendant")?

❒ No ❒ Yes, always ❒ Yes, sometimes

6. <u>Without</u> the help of someone else can you...

Request and understand written or spoken instructions?

❒ Always ❒ Sometimes ❒ Never ❒ Not sure

Cross streets and intersections?

❒ Always ❒ Sometimes ❒ Never ❒ Not sure

Stand for 10 minutes if there is no place to sit?

❒ Always ❒ Sometimes ❒ Never ❒ Not sure

Step on and off a sidewalk from the curb?

❒ Always ❒ Sometimes ❒ Never ❒ Not sure

Find your own way to the bus stop if someone shows you the way once?

❒ Always ❒ Sometimes ❒ Never ❒ Not sure

Walk up and down three steps if there is a handrail?

❒ Always ❒ Sometimes ❒ Never ❒ Not sure

Stand on a moving bus holding onto a handrail?

❒ Always ❒ Sometimes ❒ Never ❒ Not sure

Transfer from one fixed route bus to another?

❒ Always ❒ Sometimes ❒ Never ❒ Not sure

7. Under the best of conditions, what is the *farthest* you can walk (or travel using your mobility aid) without the help of another person?

❒ Less than 1 block
❒ 1 block
❒ 2 blocks (1/4 mile)
❒ 4 blocks (1/2 mile)
❒ 6 blocks (3/4 mile)
❒ more than 6 blocks
❒ I cannot travel outdoors alone at all

8. Is there anything else you want to tell about your disability or health condition that might help us to better understand your travel abilities and limitations?

_____

_____

_____

_____

_____

Signature

I understand that the purpose of this form is to determine if I am eligible to use ADA Paratransit Services. I certify that the information provided in this application is true and correct. I understand that falsification of information could result in a review of my eligibility and possible loss of ADA Paratransit Services.

I agree to notify the Cape Ann Transportation Authority if I no longer need to use ADA Paratransit Services.

_____ **Date**_____
(Signature of Applicant or Responsible Party)

If someone assisted in completing this application, please provide the following information:

Print name_____

Relationship to applicant_____

Address_____

Agency_____**Phone**_____

Authorization for Release of Information

I authorize the professional who has completed PART C of this application to release to CATA information about my disability or health condition and its effect on my ability to travel on the CATA bus service. I understand that I may revoke this authorization at any time. Unless earlier revoked, this form will permit the professional completing PART C to release the information described up to 60 days from the date below. I understand that all medical information which is provided about my disability or health condition will be kept strictly confidential.

_____ **Date**_____
(Signature of Applicant or Responsible Party)

* * * GO TO PART C * * *

PART C

This part of the form must be completed by a professional familiar with your disability or health condition and your functional abilities.

This part only needs to be completed if you are applying for "ADA Paratransit Eligibility."

1. Name of applicant:_____

2. Capacity in which you know the applicant:_____

_____

3. When was the applicant last treated or seen by you? _____

4. On average, how frequently is the applicant seen by you? _____

5. Has the applicant been diagnosed with a physical, cognitive, mental, or other disability that would prevent him or her from using fixed route CATA bus service?

   ❒ No
   ❒ Yes
   Diagnosis and date of onset:_____

   _____

   ICD-9 codes:_____

   DSM-IV codes:_____

6. The applicant's disability is:

   ❒ Permanent ❒ Temporary (until when)_____

7. Do the applicant's functional abilities to travel change due to medical treatments, environmental conditions (heat, humidity, cold, ice and snow) or other related factors?

   ❒ No
   ❒ Yes (explain):_____

   _____

8. Additional comments (prognosis, functional abilities, etc.): _____

_____

Professional's Name and Title:_____

License, Registration, or Certificate #:_____

Signature:_____

Company or Agency Name:_____

Address:_____

Phone #:_____ **Fax #:**_____