



12 Olive St, Greenfield, MA 01301 [www.frta.org](http://www.frta.org) Tel: (413)774-2262 Fax: (413)772-2202

Dear Applicant,

In order to be eligible for ADA service, a person must be unable to independently ride the FRTA's accessible fixed-route system and meet one or more of the following criteria:

- ❖ **Unconditional:**  
This is granted to a person if their disability (functional or cognitive) prevents him/her from using the fixed route bus service for *any* trip.
- ❖ **Conditional:**  
This is granted to a person that can use buses under certain circumstances, but needs to utilize our services under certain conditions, such as weather conditions or barriers to a particular trip by bus.
- ❖ **Temporary:**  
This is granted to a person on a temporary basis. The length of time will vary depending on the medical necessity.

In order to access ADA complementary paratransit transportation, eligible person's origins and destinations must be within a  $\frac{3}{4}$  mile corridor on either side of an existing FRTA bus route during the times that the fixed-route system is in operation. Hours will vary depending on the fixed route schedule. See bus schedules for availability.

The service area is available within  $\frac{3}{4}$  of a mile of our fixed routes. Origins and destinations not within  $\frac{3}{4}$  of a mile of a route are ineligible for ADA complementary paratransit service.

### **Assessing Your Eligibility for Services**

Please complete your application as thoroughly as possible. The questions will assist us in determining the specific limitations you have in using our service.

FRTA utilizes a self-certification process along with a medical verification process by the applicant's physician or health care professional who will attest to the validity the application and the ability to navigate the fixed-route system. The medical professional reviews the portion completed by the applicant for accuracy and then completes the functional and cognitive assessments.

FRTA shall use its discretion to verify the information with the individuals listed in the application form. The applicant may be called for a personal interview by phone to verify

eligibility. FRTA will review all requests for eligibility and a determination of eligibility will be made within 21 days of receipt of a completed application. Incomplete paper applications will be promptly returned with the missing information noted.

The eligibility determination letter will explain any eligibility limitations or conditions. If the applicant is determined to be ineligible, the determination letter will state the reasons for the finding. All eligibility determination letters will contain information about appeals, allowing the applicant to exercise their appeal rights and informing them of any conditions relevant to appeals. If applicable, the letter will also contain information about use of the paratransit service and policies related to its use. Information will be provided, as appropriate, in an accessible format. In the event that the 21-day time period for eligibility determination is exceeded, the applicant will be presumed eligible until a formal notification is made.

**Faxed copies will not be accepted.**

All applications and certifications will be kept strictly confidential and will not be released. We do reserve the right to verify the information reported on the application by contacting persons noted on the form.

Please return your completed application to:

Franklin Regional Transit Authority  
12 Olive St.  
Greenfield, MA 01301  
Telephone: (413) 774-2262

Persons wishing to communicate with a TTY with the FRTA should call our main number at (413) 774-2262. Please allow time to set up our machine.

All information relative to the FRTA ADA paratransit program is available (by request) in alternative forms such as Braille, cassette tape and large print formats.

## ADA PARATRANSIT APPLICATION

This application will be used solely to determine ADA eligibility for Franklin Regional Transit Authority. Please complete this application to the best of your ability.

**All questions must be answered for the application to be considered complete. Please print or type.**

Last name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt. \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_

City or Town: \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

DOB: \_\_\_\_\_

Please give us the name and telephone number of someone we can call in the event of an emergency.

Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

If this application is being filled out by someone other than the person requesting certification, please complete the following:

Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please read the following statements and circle the one that best describes what you believe is your ability to use FRTA fixed bus service by yourself. Circle only one:**

1. I don't think I can ever ride the bus independently
2. I'm really not sure if I can ride the bus.
3. I can ride sometimes, if the conditions are right.
4. I use the bus frequently.

**We would like to understand your reason for requesting the FRTA ADA Paratransit service instead of the fixed bus. Read the following statements and circle the letter that best describes how important each of these factors are to your decision.**

**A = Very Important      B = Not Important      C = Not Sure**

- |                                     |   |   |   |
|-------------------------------------|---|---|---|
| 1. Fear of Crime                    | A | B | C |
| 2. What the weather is like         | A | B | C |
| 3. Whether I have packages to carry | A | B | C |
| 4. Getting on and off the bus       | A | B | C |
| 5. Getting to and from the bus stop | A | B | C |
| 6. Navigating the system            | A | B | C |
| 7. Distance to and from a bus stop  | A | B | C |
| 8. Other: _____                     | A | B | C |

**Now circle the one factor above which is the most important to your decision.**

**The questions in this section are designed to give us a better understanding of your opinions about certain aspects of the accessible fixed bus route service. Please read each question carefully and circle the number that indicates whether you agree, disagree or are not sure.**

**Agree = 1                  Disagree = 2                  Not Sure = 3**

- |  |   |   |   |
|--|---|---|---|
| 1. The bus system is too complicated for me to figure out.   | 1 | 2 | 3 |
| 2. I've heard really good stories about FRTA fixed bus route service from other people                   | 1 | 2 | 3 |
| 3. I'm not at all interested in using the FRTA fixed bus route service for my transportation             | 1 | 2 | 3 |
| 4. I have to have a seat on the bus, and I'm worried I won't get one.                                    | 1 | 2 | 3 |
| 5. Everyone on the bus will be inconvenienced since it takes me longer to get on, people will get angry. | 1 | 2 | 3 |
| 6. Riding the bus makes me vulnerable to crime, I'm afraid to ride the bus.                              | 1 | 2 | 3 |
| 7. I think my neighborhood has good bus service.   | 1 | 2 | 3 |
| 8. I'm afraid I'll get off at the wrong stop.  | 1 | 2 | 3 |
| 9. Arriving at my destination on time is not very important to me.                                       | 1 | 2 | 3 |

10. Lower fixed route bus fares compared to ADA are an incentive for me to ride the fixed route.	1	2	3
11. Taking my trips by the fixed route will take me too long.	1	2	3
12. I need help with the tie downs and I don't think the FRTA driver will help.	1	2	3
13. I'd have to get up earlier in the morning to use the bus, which would be a problem.	1	2	3
14. I don't think the fixed bus service is reliable.	1	2	3
15. If the bus moves before I'm seated, I'm afraid I might fall.	1	2	3

**INFORMATION ABOUT YOUR DISABILITY AND MOBILITY EQUIPMENT**

**1. Please choose what type or types of disabilities prevent you from using our fixed bus route (you may choose more than one).**

Physical disability \_\_\_\_\_ Visual Impairment/blindness \_\_\_\_\_  
 Mental impairment \_\_\_\_\_ Developmental disability \_\_\_\_\_ Other \_\_\_\_\_

**2. Describe your disability and explain in detail how it prevents you from using FRTA's fixed bus route some of the time or all of the time.**

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Is this condition permanent \_\_\_\_\_ or temporary \_\_\_\_\_ if temporary, how long do you expect your condition to last? \_\_\_\_\_

Are there any other effects of your disability of which we need to be aware?

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**3. Please indicate the use of any of the following mobility aids or equipment\*:**

\_\_\_ Cane \_\_\_\_\_ Powered wheelchair

- |  |   |
|--|---|
| <input type="checkbox"/> Crutches                                | <input type="checkbox"/> Powered scooter            |
| <input type="checkbox"/> Walker                                  | <input type="checkbox"/> Manual wheelchair          |
| <input type="checkbox"/> Leg brace                               | <input type="checkbox"/> Long white cane            |
| <input type="checkbox"/> prosthesis                              | <input type="checkbox"/> Service animal             |
| <input type="checkbox"/> Portable oxygen                         | <input type="checkbox"/> Other(please specify)_____ |
| <input type="checkbox"/> I do not use any of these mobility aids |   |

\*If you use a manual or powered wheelchair or scooter, is it more than 31 inches wide, more than 45 inches long, or does it, when in use, weigh more than 800 pounds?

Yes                       No

**INFORMATION ABOUT YOUR CURRENT USE OF FRTA FIXED BUS ROUTE SERVICE**

Do you currently use the FRTA fixed bus route service?     Yes     No

When was the last time you used the FRTA fixed route service? \_\_\_\_\_

Which bus route(s) serve your neighborhood, and what is the closest bus stop? Please give the Route name and location (ex. Route 21 Greenfield, Franklin Medical Center). You may call FRTA customer service at 413-774-2262 for information about bus routes and stops in your neighborhood.

\_\_\_\_\_

Can you get to the stop by yourself? (check one)

Sometimes \_\_\_\_\_                      Not Sure \_\_\_\_\_                      Yes \_\_\_\_\_                      No \_\_\_\_\_

If not, why? \_\_\_\_\_

\_\_\_\_\_

**YOUR FUNCTIONAL ABILITY**

Your answers to the questions in this section will help us better understand your functional ability in specific areas. For each question, circle 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 independently.

**Can you:**

**1. Walk up and down three (3) steps if there are handrails?**

Always                      Sometimes                      Never                      Not Sure

**2. Use the telephone to get information?**

Always            Sometimes            Never            Not Sure

**3. Travel one level block on the sidewalk if the weather is good?**

Always            Sometimes            Never            Not Sure

**4. If you are able to do this, how long does it take you?**

Less than five (5) minutes            Five (5) to ten (10) minutes            Not Sure

**5. Cross the street if there are curb cuts?**

Always            Sometimes            Never            Not Sure

**6. Ride up and down a wheelchair lift with handrails on both side?**

Always            Sometimes            Never            Not Sure

**7. When the weather is good, travel three (3) level blocks on the sidewalk?**

Always            Sometimes            Never            Not Sure

**8. If you are able to do this, how long does it take you?**

Less than five (5) minutes            Five (5) to ten (10) minutes            Not Sure

**9. Wait fifteen (15) minutes at a bus stop that does not have a seat and a shelter?**

Always            Sometimes            Never            Not Sure

## **FUNCTIONAL ABILITY, CONTINUED**

**10. Travel up or down a gradual hill on the sidewalk, if the weather is good?**

Always            Sometimes            Never            Not Sure

**11. Find your own way to the bus stop?**

Always            Sometimes            Never            Not Sure

**12. Are you currently able to travel by yourself?**

Always            Sometimes            Never            Not Sure

**13. If you need assistance from another person, how do they assist you?**

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**14. What barriers in your surroundings make it difficult for you to use the fixed bus route?**

Circle all that apply:

Lack of curb cuts      No sidewalks      Steep hills      Busy streets I must cross

Sidewalks are in poor condition (holes, etc.)

Other: \_\_\_\_\_

### **WEATHER RELATED CONSIDERATIONS**

1. Does the weather affect your ability to use the FRTA fixed bus service? \_\_\_yes \_\_\_no

2. If you answered yes, please explain how: \_\_\_\_\_

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\_\_\_ I cannot travel through deep snow or when there is ice

\_\_\_ I cannot travel at night due to night blindness

\_\_\_ Very cold weather is dangerous to my health

\_\_\_ Very hot weather is dangerous to my health

\_\_\_ High air pollution (smog, etc.) is dangerous to my health

\_\_\_ Other. Explain: \_\_\_\_\_

### **THE ENVIRONMENT AROUND YOUR HOME**

1. How many steps are at the entrance you use at your residence? \_\_\_\_\_



2. Can you get to the FRTA vehicle without any help from another person at your residence?

\_\_\_\_\_ yes                      \_\_\_\_\_ no

3. If not, why? \_\_\_\_\_

4. How would you describe the terrain where you live? (Ex: steep hill, flat, gradual hill, etc.)

\_\_\_\_\_

5. Are there sidewalks in your neighborhood?    \_\_\_\_\_ yes                      \_\_\_\_\_ no

**YOUR CURRENT TRAVEL**

1. List your four (4) most frequent destinations and how you get there now:

Destination address	How often you go there	How you get there now
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_____		
_____		
_____		
_____		

Please use this space to tell us anything else you would like us to know about your travel challenges and your ability to use the FRTA bus service:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Did you require any assistance to complete this form?    \_\_\_\_\_ Yes    \_\_\_\_\_ No

If yes, how did that person help you? \_\_\_\_\_

\_\_\_\_\_

**Please review the questionnaire to make sure that you have answered all of the questions to the best of your ability.**

I hereby understand that in order to be eligible to use ADA Paratransit service, I must have a disability which makes me unable to use the FRTA fixed route service. I agree that if any of the information given to the FRTA is materially false or misleading, the FRTA shall have the right to reconsider my eligibility for ADA paratransit services. I certify that the information given above is correct. I understand that the FRTA may contact the health care professional who has completed the medical verification attached to this application in order to confirm information included in this application.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

In order to allow the FRTA to evaluate your application it will be necessary to have your Physician or other Professional confirm the information you have provided and return it with your application. **Faxed copies will not be accepted.**

**PROFESSIONAL VERIFICATION FOR ADA PARATRANSIT SERVICES**

**IMPORTANT NOTICE: The information, which you provide, will assist the FRTA in determining your patient’s functional and cognitive ability to use public transportation. This form assists the FRTA in determining when and under what circumstance the consumer can utilize the bus system. All of our vehicles are equipped with a wheelchair lift for individuals who need to use a wheelchair or cannot climb stairs. It is essential that you be as precise as possible in your evaluation. All information on this form will be kept strictly confidential and will not be released. Thank you for your cooperation.**

Name of Physician or Health Care Professional completing this form:

\_\_\_\_\_

Office Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

1. In what capacity do you know this individual? \_\_\_\_\_

\_\_\_\_\_

2. How long have you known this individual? \_\_\_\_\_  
\_\_\_\_\_

3. When was the last face to face contact with this individual? \_\_\_\_\_  
\_\_\_\_\_

4. What is the individual's diagnosis? \_\_\_\_\_

5. Is the person taking medication? \_\_\_\_\_

6. Do you deem the individual to be compliant in taking medication? \_\_\_\_\_  
Does the medication affect the individual's functional ability to travel independently within the community? If yes, how? (drowsiness, confusion, etc.) \_\_\_\_\_  
\_\_\_\_\_

7. Is the individual's disability the same every day? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, please answer the following:

What is a "good day" like? \_\_\_\_\_  
\_\_\_\_\_

What is a "bad day" like? \_\_\_\_\_  
\_\_\_\_\_

How many "good/bad" days has the individual had in the last month?

\_\_\_\_\_ "good" day \_\_\_\_\_ "bad" days

Does anything trigger a "bad" day? Yes \_\_\_\_\_ No \_\_\_\_\_ Explain: \_\_\_\_\_  
\_\_\_\_\_

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

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Disorientation    | <input type="checkbox"/> Concentration   | <input type="checkbox"/> Communication                 |
| <input type="checkbox"/> Problem-solving   | <input type="checkbox"/> Gait or Balance | <input type="checkbox"/> Inconsistent performance      |
| <input type="checkbox"/> Short term memory | <input type="checkbox"/> Monitoring time | <input type="checkbox"/> Coping skills                 |
| <input type="checkbox"/> Long term memory  | <input type="checkbox"/> Judgement       | <input type="checkbox"/> Inappropriate social behavior |
| <input type="checkbox"/> Other _____       |  |  |

Please explain how the above interferes with safe community travel:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Does the individual demonstrate inappropriate social behavior? \_\_\_ Yes \_\_\_ No

If yes, please describe \_\_\_\_\_  
\_\_\_\_\_

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

- Traveling alone outside \_\_\_\_\_
- Leaving the house on time \_\_\_\_\_
- Seeking and acting on directions \_\_\_\_\_
- Finding way to/from the bus stop \_\_\_\_\_
- Crossing streets \_\_\_\_\_
- Waiting for the bus \_\_\_\_\_
- Boarding the correct bus \_\_\_\_\_
- Riding on the bus \_\_\_\_\_
- Transferring to a second bus \_\_\_\_\_
- Monitoring time \_\_\_\_\_

11. Would mobility training be appropriate for this individual?  Yes  No

If no, why? \_\_\_\_\_  
\_\_\_\_\_

I certify that this information is true and correct to the best of my knowledge.

Signature \_\_\_\_\_ Title \_\_\_\_\_

\_\_\_\_\_  
Please print or type name

\_\_\_\_\_  
Please print or type title

Agency \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Thank you for your time and input.

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