



Bay Area Rural Transit
Public Transit
ADA Certification Application
 (Americans with Disabilities Act)



If you are at least 60 years of age – STOP – you do not need to complete this form.
You already qualify for the Senior rate.

VERIFICATION is required to certify that you qualify for ADA Bus services if you are under the age of 60 years. Evaluation of your request will begin as soon as the form is completed and received. The information obtained in this request will be used by Bay Area Rural Transit (BART) for the provision of transportation services. Information may be shared with BART partner agencies that provide ADA services on our behalf. Return the completed, signed form to BART, PO Box 612, Ashland, WI 54806. You will be notified of our determination within 14-21 days after we receive your request. If you have any questions, please call the BART Manager 715-682-9664.

1. Name *(please print)* _____ Date of Birth _____
 Address _____ Telephone # _____
 City/State/Zip _____

2. The limitation qualifying me is based on my inability to perform one or more of the following functions necessary for the effective use of mass transportation facilities without significant difficulty **(check all that apply)**.

- board or alight from an auto, van and/or bus
- stand in a moving bus
- Permanent
- read informational signage
- hear announcements by driver
- Temporary (If temporary, expected duration _____)

3. How far can you walk without the assistance of another person?
 1 block 2-3 blocks 4-9 blocks

4. Is your ability to travel affected by extremes in the weather? Yes No

If yes, please explain: _____

5. Do you require a Personal Care Attendant?

- No
- Yes
- Sometimes

If yes, please explain: _____

6. Other effects of your limitations of which BART needs to be aware: _____

Description of Disability: Check all that apply.

- Physical
- Intellectual
- Sensory

Indicate nature of applicant's disability (check all that apply)

Impaired or assisted ambulation.

Specify mobility aid _____

Arthritis

Specify extremity _____

Cerebrovascular Accident

Pulmonary: Does applicant travel with Portable Oxygen Tank?

Yes _____

No _____

Neurological Handicap

Specify _____

Cardiac

Mental Retardation (indicate one)

Moderate: _____

Severe: _____

Profound: _____

Kidney Disease

Dialysis

Legally Blind

Severely Visually Impaired

Alzheimer's

Dementia

Cerebral Palsy

Autism

Deaf/Hard of Hearing

Seizures

Specify _____

Mental Illness

Specify _____

Other

Specify _____

The following information will be used to ensure that an appropriate vehicle is utilized to provide your transportation and that an accurate analysis of your trip requests can be made by BART.

7. Do you use any of the following aids for MOBILITY? **(check all that apply)**

- | | | |
|--------------------------------------------|----------------------------------------------|------------------------------------------|
| <input type="checkbox"/> manual wheelchair | <input type="checkbox"/> electric wheelchair | <input type="checkbox"/> powered scooter |
| <input type="checkbox"/> cane | <input type="checkbox"/> crutches | <input type="checkbox"/> guide dog |
| <input type="checkbox"/> Walker | <input type="checkbox"/> segway | |

8. If this REQUEST FOR CERTIFICATION has been completed by someone other than the person needing service that person must complete/sign the following:

Name <i>(please print)</i> _____	Telephone # _____
Address _____	_____
_____	Relationship to Applicant: _____
City/State/Zip _____	
Signature _____	Date _____

9. In order for BART to evaluate the request, it may be necessary to contact a physician or other professional to confirm the provided information.

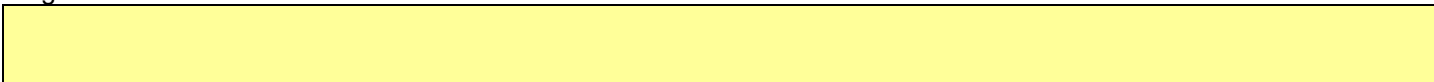
Please complete the following information and authorization form.

The following Physician Health Care Professional Rehabilitation Professional is familiar with my DISABILITY and is authorized to provide required information to Bay Area Rural Transit to complete the REQUEST for CERTIFICATION:

Name <i>(please print)</i> _____	_____
Address _____	Dr. Name _____
City, State & Zip _____	(_____) _____
	Phone Number _____
_____	_____
Signature of Person Requesting Certification _____	Date _____

10. I hereby CERTIFY that the information given above is correct:

Signature _____	Date _____
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BAY AREA RURAL TRANSIT USE (only)

Date Received: _____ Date Processed: _____ (21 days max.)

Applicant' Name _____ approved not approved

Certified by _____ Date _____ permanent temporary (to: _____)

Mobility Manager Review Date: _____

Doctor Review Needed yes no If needed Date sent _____ Date received _____

Review Action Letter Sent: _____ ID Included

Copy of Approval Sent to: Ashland County Aging _____ or Bayfield County Aging _____ or Price County Aging _____
(Date) (Date) (Date)

Return to:
Pat Daoust, Transit Manager
Bay Area Rural Transit
2216 Sixth Street East
P.O. Box 612
Ashland, WI 54806

Customer #: _____
Date Entered: _____
Initials: _____

Direct questions to Pat Daoust, Manager: (715) 682-9664 Ext. 101

FORM B
Request for Certification of Americans with Disabilities Act (ADA)
Professional Review Certification

From: Bay Area Rural Transit (BART)

To: _____

_____ has authorized you to provide us with information regarding his/her eligibility for the BART's Americans with Disabilities Act, Transit Assistance program. Your confirming information will assist us in making evaluation of their need/request. Thank you for your cooperation in this matter.

Relationship to applicant: Physician Health Care Professional Rehabilitation Professional

Condition causing disability: Permanent Temporary (expected duration _____)

If the person has a MOBILITY disability, is the person able to:	YES	NO	Occasionally
Walk 1 block without assistance of another person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk 2-3 blocks without assistance of another person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk 4-9 blocks without assistance of another person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb 3 steps without assistance of another person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wait outside without support for up to 10 minutes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Use mobility aids? Describe _____

Does the person have an uncorrectable VISUAL IMPAIRMENT? NO YES Right Eye Left Eye Both Eyes

If the person has a COGNITIVE disability, is the person able to:	YES	NO
Give address and telephone number upon request	<input type="checkbox"/>	<input type="checkbox"/>
Recognize a destination or landmark	<input type="checkbox"/>	<input type="checkbox"/>
Deal with unexpected situation or unexpected change in routine	<input type="checkbox"/>	<input type="checkbox"/>
Ask for, understand and follow directions	<input type="checkbox"/>	<input type="checkbox"/>
Safely & effectively travel through crowded and/or complex facilities	<input type="checkbox"/>	<input type="checkbox"/>

Any other effect of the disability of which BART should be aware? _____

Authorizing Professional:

Name *(please print)* _____

Office Telephone # _____

Address _____

City _____ State _____ Zip _____

Signature _____

Date _____

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Pat Daoust, Transit Manager
Bay Area Rural Transit
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