



# Paratransit Eligibility Application

This is part of an application is for paratransit (van) services under the  
**Americans with Disabilities Act (ADA).**

## **Form II: Health Care Professional Verification**

To be completed by a physician or an approved health care professional only.

Please **PRINT** or **TYPE**. Use additional sheets if needed.  
Complete all sections which are relevant to the applicant's disability(ies).

Spartanburg Area Regional Transit Agency (SPARTA) provides complementary paratransit services (origin to destination transportation provided in lift-equipped vehicles) to individuals who cannot utilize our fixed route service (our regular large bus system). To be eligible for this paratransit service, individuals must have one or more physical or mental disabilities which prevent use of the fixed route service. *Neither age, economic status, nor distance to the nearest bus stop by themselves constitutes eligibility.*

Please answer the following questions as they pertain to \_\_\_\_\_, who has asked us to forward this application to you on his/her behalf.

As a professional familiar with the applicant's medical history, please complete this form documenting the disability or condition that prevents his or her use of the regular bus system. Please assist us by certifying only those individuals that are truly unable to use the regular bus system.

### **A. General Information** *Complete for all applicants.*

What capacity do you know this person? \_\_\_\_\_

\_\_\_\_\_

What disability(ies) prevent(s) this person's use of a regular fixed route service? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Form II: Health Care Professional Verification (cont.)**

How does the disability(ies) prevent(s) the use of a regular fixed route service? Please be complete.

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Is this temporary?  Yes  No If "Yes", expected duration? \_\_\_\_\_

**B. Physical Mobility** *Complete for applicants whose disability physically limits his/her mobility.*

Does this person use any of the following mobility aids:

- |   |   |
|---|---|
| <input type="checkbox"/> Manual Wheelchair                      | <input type="checkbox"/> Service Animal         |
| <input type="checkbox"/> Electric Wheelchair                    | <input type="checkbox"/> Walking Cane           |
| <input type="checkbox"/> Powered Scooter                        | <input type="checkbox"/> Portable Oxygen        |
| <input type="checkbox"/> White cane (for the visually-impaired) | <input type="checkbox"/> Personal Assistant/PCA |
| <input type="checkbox"/> Crutches                               | <input type="checkbox"/> Other _____            |
| <input type="checkbox"/> Walker                                 | _____   |

If this person uses a riding mobility aid, how many blocks can he/she travel without help? (One block = approx. 500 ft.) \_\_\_\_\_ block(s). How does this person's disability prevent him/her from traveling more blocks? \_\_\_\_\_

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If this person uses a riding mobility aid (i.e. wheelchair or scooter), can he/she get on and off of a wheelchair lift independently on a lift equipped with handrails? (Lifts are operated by the drivers.)

Yes  No If no, explain why not. \_\_\_\_\_

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If this person can walk, with or without a mobility aid, how many blocks can he/she walk without help? (One block = approx. 500 ft.) \_\_\_\_\_ block(s). How does this person's disability prevent him/her from walking more blocks? \_\_\_\_\_

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How many 9-inch steps can this person climb without help? \_\_\_\_\_

How does this person's disability prevent him/her from climbing more? \_\_\_\_\_

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**Form II: Health Care Professional Verification (cont.)**

If this person is unable to climb steps, could he/she stand, hold onto the handrails, and ride up into a bus on a wheelchair lift? (Lifts are operated by the drivers.)  Yes  No If "No", explain why not. \_\_\_\_\_

How many minutes can this person wait at a bus stop? (with or without a mobility device) \_\_\_\_\_

How does this person's disability prevent him/her from waiting longer? \_\_\_\_\_

**C. Cognitive Ability** *Complete for applicants with a cognitive disability.*

Can this person read informational signs?  Yes  No If "No", please explain. \_\_\_\_\_

Can this person navigate independently?  Yes  No  Sometimes  
If "No" or "Sometimes", please explain. \_\_\_\_\_

Can this person give his/her address, destination and telephone number upon request?  
 Yes  No  Sometimes If "Sometimes", please explain when. \_\_\_\_\_

Can this person recognize a destination or landmark?  Yes  No  Sometimes  
If "Sometimes", please explain when. \_\_\_\_\_

Can this person ask for, understand, and follow directions?  Yes  No  Sometimes  
If "Sometimes", please explain when. \_\_\_\_\_

Can this person deal with unexpected situations or changes in routine?  
 Yes  No  Sometimes If "No" or "Sometimes", please explain. \_\_\_\_\_

**Form II: Health Care Professional Verification (cont.)**

**D. Visual Ability** *Complete for applicants with a visual impairment.*

Can this person read informational signs?  Yes  No If "No", please explain.

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Can this person navigate independently?  Yes  No  Sometimes If "No" or "Sometimes", please explain. \_\_\_\_\_

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Has this person received mobility training?  Yes  No  Unknown

If "No", is this person on a waiting list to be mobility trained?  Yes  No  Unknown

If "Yes", approx. when will the training begin? \_\_\_\_\_

**E. General Ability** *Complete for all applicants.*

What specific weather conditions, if any, affect this person's mobility? Please explain completely.

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What terrain or road and sidewalk conditions, if any, affect this person's mobility? Please explain completely. \_\_\_\_\_

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Will this person require any assistance while traveling on our vehicle?

Never  Always  Sometimes If "Always" or "Sometimes", explain what, why and when.

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Will this person require a Personal Attendant/PCA while traveling on our vehicle?

Never  Always  Sometimes If "Sometimes", explain when. \_\_\_\_\_

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**Form II: Health Care Professional Verification (cont.)**

Please describe any other functional limitation(s) affecting this person's mobility not described above. Be specific. \_\_\_\_\_

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In your professional opinion, does this applicant's disability prevent him/her from getting to or from, boarding, riding, or disembarking a regular Fixed route service?

Yes  No  Sometimes

\_\_\_\_\_  
Signature of Health Care Professional

\_\_\_\_\_  
Date

Name & Title: \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_

Office Telephone: \_\_\_\_\_

Return Completed form to:

**Transit Management of Spartanburg  
P.O. Box 1607, 150 Air Flow Drive  
Spartanburg, South Carolina 29304**