



# Paratransit Eligibility Application

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

## **Form I: Information from the Applicant**

To be completed by applicant or representative.

*Please PRINT or TYPE.*

Name: \_\_\_\_\_ Date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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

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

Telephone:  Home ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Alternative/Work ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

### 1. What disability(ies) prevent(s) you from riding the regular bus service?

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

### 2. Do you use any of the following mobility aids:

Manual Wheelchair

Service Animal

Electric Wheelchair

Walking Cane

Powered Scooter

Portable Oxygen

White cane (for the visually-impaired)

Personal Assistant/PCA

Crutches

Other \_\_\_\_\_

Walker

\_\_\_\_\_

*(Note: We may not be able to accommodate you if your wheelchair or scooter is longer than 48", wider than 30", or if your total weight with your mobility device is more than 600 pounds.)*

**Form I: Information from the Applicant** (cont.)

3. *Please read the following statements and check (✓) any which describe(s) you. You may select more than one.*

- I have a disability which prevents me from boarding a regular fixed route service which does not have a lift.
- I have a disability which prevents me from boarding a fixed route service with a lift.
- I have a disability which prevents me from getting to a bus stop.
- I am afraid to ride the fixed route service.
- I have no knowledge of or experience with fixed route service, so I do not know if I am able to use it.
- There is no fixed route service bus stop near my residence.
- I can't get to a bus stop by myself, because I get disoriented or confused.
- I have a temporary disability which prevents me from taking a regular fixed route service. I will only need to use paratransit service until I recover.
- If given instructions or training on fixed route service, I think I could use it.
- My trips by fixed route service would take me too long.
- I have an episodic disability. I can use the fixed route service on those days when I am feeling well, but on "bad days", I cannot.

*Please answer the following questions as they pertain to your physical mobility.*

4. **If you use a riding mobility aid, how many blocks can you travel without help?**

(One block = approx. 500 ft.) \_\_\_\_\_ block(s)

5. **If you use a riding mobility aid (i.e. wheelchair or scooter), can you get on and off of a wheelchair lift independently?**

(Lifts are operated by the drivers.)  Yes  No

6. **If you can walk, with or without a mobility aid, how many blocks can you walk without help?** (One block = approx. 500 ft.) \_\_\_\_\_ block(s)

**Form I: Information from the Applicant** (cont.)

7. How many 9-inch steps can you climb without help? \_\_\_\_\_
8. If you are unable to climb steps, could you stand, hold onto the handrails, and ride up into a bus on a wheelchair lift if the bus was so equipped?  
(Lifts would be operated by the drivers.)  Yes  No
9. How long (with or without a mobility device) can you wait at a bus stop? \_\_\_\_\_ min.
10. Are you able to grasp coins, tickets, and handles?  Yes  No

*Please answer the following questions as they pertain to your cognitive ability.*

11. Can you read informational signs?  Yes  No
12. When you travel, can you find your way around by yourself?  Yes  No
13. Can you give your address, destination and telephone number?  Yes  No
14. Can you recognize a destination or landmark?  Yes  No
15. Can you ask for, understand, and follow directions?  Yes  No
16. Can you deal with unexpected situations or changes in routine?  Yes  No

*Please answer the following questions as they pertain to your visual ability (sight).*

17. Can you read informational signs?  Yes  No
18. Can you recognize a destination or landmark?  Yes  No
19. When you travel, can you find your way around by yourself?  Yes  No
20. Have you received mobility training?  Yes  No  
If No, are you on a waiting list to be mobility trained?  Yes  No  
If Yes, approx. when will the training begin \_\_\_\_\_
21. What specific weather conditions, if any, affect your ability to ride a regular fixed route bus. \_\_\_\_\_

**Form I: Information from the Applicant** (cont.)

*Please answer the following questions as they pertain to your general ability.*

22. What terrain, road and sidewalk conditions, if any, affect your ability to ride a regular fixed route bus? \_\_\_\_\_

23. Will you require any assistance while traveling on our vehicle?

Never  Always  Sometimes If **Always** or **Sometimes**, explain what and when.

\_\_\_\_\_

24. Do you travel with a Personal Attendant/PCA?  Never  Always  Sometimes If **Sometimes**, explain when \_\_\_\_\_

25. Please describe any other effects your disability might have on your ability to ride a regular bus, not described above. Be specific. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

26. Please list the most common destinations to which or from which you travel.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Release of Information and Applicant Signature

I, the applicant, understand that the purpose of this application is to determine my eligibility to use the Spartanburg Area Regional Transit Agency complementary paratransit service. I agree to release the information requested to Transit Management of Spartanburg (TMS) and any eligibility review panel, and understand that the information contained herein will be treated confidentially.

I certify that the information I gave in this application is true and correct. I understand that falsification of information may result in denial of service. I understand that TMS may contact the health care professional that I have listed below who may be asked to complete the Professional Verification (Form II) of this application in order to confirm this information or provide further information.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**- OR -**

*If this form is completed by someone other than the applicant, respond to the following:*

### Information from Person Completing Form for Applicant

I have read the information under **Release of Information** above, and have relayed the information to the applicant, the applicant's guardian, or have the legal authority to accept these rights and provisions on behalf of the applicant.

\_\_\_\_\_  
Signature of Person Completing Form for Applicant

\_\_\_\_\_  
Date

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: (Home) (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (Work) (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Please provide the name of a health care professional or physician who is familiar with your disability(ies) and what effect it/they have on your mobility. It may be necessary to have this individual complete Form II (Health Care Professional Verification) in order to determine your eligibility for this paratransit service.**

***(Important note: The person completing Form I of this application for the applicant cannot also be the person completing Form II - Health Care Professional Verification)***

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

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

Office Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Form I: Information from the Applicant** (cont.)

Return Completed form to:

**Transit Management of Spartanburg  
PO Box 1607, 150 Air Flow Drive  
Spartanburg, South Carolina 29304**

Attn: Eligibility Manager

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*For office use only*

Eligible?  Yes

I.D. # \_\_\_\_\_

Conditional (Conditions: \_\_\_\_\_)

Temporary (Expiration: \_\_\_\_ / \_\_\_\_ / \_\_\_\_)

No

Determination Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_