

Application For Certification of ADA Paratransit Eligibility



**If you have special needs and require this application
in a different format, or would like more information,
call 394-6230 or (TDD: 394-CATA).**

Application For Certification of ADA Paratransit Eligibility

The information obtained in this certification process will only be used by CATA for the provision of transportation services. Information will only be shared with other transit providers to facilitate travel in those areas.

1. Name _____

2. Home Address _____
(Specify exact street, road, avenue, etc.)
_____ Apt. # _____

City _____ State _____ Zip _____

3. Telephone number (Home) _____ (Work) _____

4. Date of birth ___/___/___ Social Security No. _____

5. What is the disability which prevents you from using our fixed route service? _____

Is this condition temporary?

Yes ___ No ___ If yes, expected duration until ___/___/___

6. How does this disability prevent you from using fixed route services? Please explain completely. Use an additional sheet if needed.

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

The following information will be used to insure that an appropriate vehicle is utilized to provide your transportation and that an accurate analysis of your trip requests can be made by the Capital Area Transportation Authority.

8. Do you use any of the following aids to mobility? (Check all that apply)
Manual wheelchair ___ Electric wheelchair ___ Powered scooter ___
Are you able to transfer out of your wheelchair? ___ Yes ___ No
Cane ___ Crutches ___ Guide dog ___

9. Do you require a Personal Care Attendant when you travel using transit?
Yes ___ No ___ Sometimes _____

10. Please answer the following questions:

Can you travel 200 feet without the assistance of another person?
Yes ___ No ___ Sometimes (Please explain) _____

Can you travel 1/4 mile without the assistance of another person?
Yes ___ No ___ Sometimes (Please explain) _____

Can you travel 3/4 mile without the assistance of another person?
Yes ___ No ___ Sometimes (Please explain) _____

How far do you live from a CATA bus route? _____
Which route? _____

Can you wait outside for ten minutes?
Yes ___ No ___ Sometimes (Please explain) _____

11. I hereby certify that the information given in this application is correct.

Applicant's Signature _____ Date ___ / ___ / ___

12. If this application has been completed by someone other than the person requesting certification, that person must complete the following:

Name _____

Address _____

City _____ State _____ Zip _____ Daytime phone _____

Signed _____ Date ___ / ___ / ___

In order to allow CATA to evaluate your application, it may be necessary to contact a physician or other professional to confirm the information you have provided. Please complete the following information and authorization form.

The following (check one)

Physician ___ Health Care Professional ___ Rehabilitation Professional ___
is familiar with my disability and is authorized to provide information to the Capital Area Transportation Authority required to complete this certification.

Professional's Name _____

Address _____

City _____ State _____ Zip _____ Professional's
Phone number _____

Applicant's signature _____ Date ___ / ___ / ___

Please return this form to:

CAPITAL AREA CENTER FOR INDEPENDENT LIVING
1048 PIERPONT STE 9-10
LANSING MI 48911

You _____ writing.