



Americans with Disabilities Act (ADA)
Paratransit Eligibility Application
Professional Verification Form

Paratransit Services Provided by Mountain Mobility

828.250.6750 • mountainmobility@buncombecounty.org • 339 New Leicester Hwy, Suite 140 – Asheville, NC 28806

Note: This form is intended to be filled out by a medical or social service provider, so that their professional opinion can be used to certify the applicant/patient for ADA paratransit service.

Applicant Name: _____ Applicant DOB: _____

Name/Description of applicant’s condition (s) AND their mobility in general: _____

In your professional opinion, does the applicant’s condition make him/her **unable** to ride the fixed-route buses or to get to/from bus stops? If a condition only makes it **difficult** or **inconvenient** for the applicant to use the fixed-route system, he/she is not eligible for paratransit.

Certifying Professional’s Information

Name and Job Title: _____

Name of Organization/Office: _____

Office Address: _____

Phone: _____ Email: _____

Instructions for Submitting This Form

If the applicant requests that you return this form to them, please return it to them in an official, sealed office envelope. Otherwise, you can submit it to Mountain Mobility at the physical or email address found above. If submitting by mail, please direct your letter to the attention of Mountain Mobility Administration followed by the address.