City of Asheville and Mountain Mobility

Americans with Disabilities Act (ADA)

Paratransit Eligibility Application

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

PART 1 Applicant Information

Name_____ Birth Date____/____/____

Street Address_____ Apt #_____

City_____ State_____ Zip_____

Phone_____ Email_____

Emergency Contact Person

Name_____ Relation_____

Phone (daytime)_____ Phone (evening)_____

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PART 2 Condition/Disability Details

1. Please explain your disability or health condition(s): _____

_____

_____

2. Is your health condition or disability **permanent** or **temporary**? (circle one.)
3. Does the severity of your condition change from day to day, or after visiting a doctor? Please explain:_____

_____

4. Does your condition require the use of a **walker**, **cane**, **wheelchair**, **oxygen tank**, or **other device**? (circle all that apply.) If other, please specify:_____
5. Does your condition require you to travel with a **companion** or **service animal** to assist you? (circle all that apply.)

PART 3 Questions About Mobility

6. Can you use the fixed-route bus system without assistance? **Yes** **No** **Sometimes**

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7. If you answered "No" or "Sometimes", please explain what prevents you from independently using the fixed-route bus system: _____

_____

For the following statements, please circle yes, no or sometimes.

I can tolerate very hot or very cold weather	**Yes**	**No**	**Sometimes**
I can read maps, schedules and signage.....	**Yes**	**No**	**Sometimes**
I can follow travel directions.....	**Yes**	**No**	**Sometimes**
I can adapt to bus detours and changes in schedules.....	**Yes**	**No**	**Sometimes**
I can identify the correct bus and bus stop.....	**Yes**	**No**	**Sometimes**
I can get on and off a bus, using a lift if necessary.....	**Yes**	**No**	**Sometimes**
I can use fare boxes and request necessary transfers.....	**Yes**	**No**	**Sometimes**
I am free from night blindness.....	**Yes**	**No**	**Sometimes**
I can hear and comprehend spoken information.....	**Yes**	**No**	**Sometimes**
I can communicate personal needs.....	**Yes**	**No**	**Sometimes**
I can recognize and navigate curb cuts or drop-offs.....	**Yes**	**No**	**Sometimes**
I can travel independently along walkways.....	**Yes**	**No**	**Sometimes**
I can cross a street independently.....	**Yes**	**No**	**Sometimes**
I can navigate steep hills or other difficult terrain.....	**Yes**	**No**	**Sometimes**

If you answered "No" or "Sometimes" for any of the above statements, please explain below.

_____

_____

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PART 4 Rider Agreements

☐ I certify that the information contained in this application is true and complete to the best of my knowledge. I understand that any falsification of information on this form may lead to disqualification for ADA paratransit service.

☐ I authorize the health care professional completing the verification statement to release to Mountain Mobility any protected health information about my disability in order to verify my eligibility for ADA paratransit service.

FOR STAFF:

☐ This person is qualified for ADA Paratransit service on a temporary basis until _____ (the date 30 days after submission of the application), pending a verification letter.

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PART 5 Required Verification Letter

To complete your application, **you must** submit a signed verification letter from a medical or social service provider alongside this form. Our **Professional Verification Letter** can be found on the next page. We strongly encourage you to use our standard letter, but you can submit another letter if you prefer, as long as it contains the following information:

- Your name and date of birth
- A description of your condition **and** how it affects your mobility
- Whether your condition is temporary or permanent
- Whether your condition makes you unable to ride the fixed-route bus system
- Name, title and signature of the certifying professional
- Contact information for the professional and/or their organization

Have your medical or social service provider complete the form, and they can either return it to you for submission or they can submit it directly on your behalf. Please note that if you choose to submit all of your materials by email, your verification letter must be emailed to us by the certifying professional, not by you. If you or the professional sends the letter by mail, it must be mailed to us in an official sealed envelope.

The following medical and social service providers can submit a form verifying your eligibility:

- Physician, Psychiatrist, Osteopath, Podiatrist, Optometrist, Audiologist, Otolaryngologist, Certified Physical Therapist
- Mental health or behavioral service/counseling provider, community health center, HIV/AIDS services, rehabilitation services, centers for independent living (including Disability Partners), and NC Division of Services for the Blind

If you know of a service provider that is not mentioned above but should be eligible to submit a verification letter, please contact the City of Asheville at iride@ashevillenc.gov .

Medical and Social Service Providers: Please complete the form on the next page, and return the verification letter to the applicant for submission, or you can submit it directly by email to: *mountainmobility@buncombecounty.org* or by mail to:

attn.: Mountain Mobility, LOSRC
339 New Leicester Hwy, Suite 140
Asheville, NC 28806

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Paratransit Eligibility Application
Professional Verification Letter

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Note: This form should 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: _____

Description of applicant's condition (s) and how it affects their mobility: _____

_____

_____

Is the applicant's condition permanent or temporary? If temporary, give the expected duration.

_____

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 without assistance or training? _____

_____

_____

Certifying Professional's Information

Print Name and Job Title: _____

Signature: _____

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 envelope. Otherwise, you can submit it directly 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, LOSRC, followed by the address.