



Request for Renewal Certification of ADA Paratransit Eligibility

The information obtained in this certification process will only be used by the South Bend Public Transportation Corporation (Transpo) for the provision of transportation services. The information will not be shared with any other person or agency.

Part A: Applicant Profile

Please type or print.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Initial: \_\_\_\_\_

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

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

Main Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Date of Birth (month/day/year): \_\_\_\_\_

Emergency Contact:

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

Main Phone: \_\_\_\_\_ Alternate: \_\_\_\_\_

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FOR OFFICE USE ONLY

Application Received: \_\_\_\_\_ Professional Verification Mailed: \_\_\_\_\_

Professional Verification Received: \_\_\_\_\_

Application Received with Professional Verification: \_\_\_\_\_

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

Mobility Aid: \_\_\_\_\_ PCA: \_\_\_\_\_

Conditions: \_\_\_\_\_

Determination Mailed: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ Card # \_\_\_\_\_

Renewal Mailed: \_\_\_\_\_ Second Notice: \_\_\_\_\_ Final Notice: \_\_\_\_\_

**Part B: Paratransit Service Certification**Disability or Health Condition Information

1. What is the nature of your disability or health condition (be specific)?

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2. Is your condition temporary?  Yes  No

If temporary, how long do you expect it to last? \_\_\_\_\_

3. Does your disability or health condition change from time-to-time in ways which affect your mobility?  Yes  No

If yes, please describe: \_\_\_\_\_

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Mobility Information

1. Which of these mobility aids or equipment do you use to help get you where you need to go? (Check all that apply)

Manual Wheelchair  Powered Wheelchair/Scooter  Crutches

Cane  Service Dog  Walker  None

Other \_\_\_\_\_

2. Do you require a Personal Care Attendant when using Access?  Yes  No

3. Can you travel three blocks without assistance from another person?

Yes  No

4. Can you climb three 12-inch steps without assistance from another person?

Yes  No

5. Can you wait outside without support for 10 minutes?

Yes  No

6. Can you communicate with a bus driver with or without an aid (such as a picture board or route ID cards)?  Yes  No



7. Do you ride the fixed route Transpo buses?  
 Yes, regularly     Yes, occasionally     No, but I used to     No

8. Are there any other conditions which limit your ability to use the regular fixed route buses?     Yes     No

If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

Applicant Verification

**Applicant Signature**

I certify that the information given in this application is true and correct. I understand that falsifying of information may result in denial of service. I understand all information will be kept confidential and only the information required to provide service will be disclosed to those who perform such service. I understand that for confirmation, Transpo may contact the health care professional who completed the professional verification form attached to this application.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Person Completing Form (if other than applicant)**

I certify that the information provided in this application is true and correct based on either the information given to me by the applicant or upon my knowledge of the applicant's health condition or disability.

Name: \_\_\_\_\_ Relationship to Applicant \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_