For office use only

Request for Certification of ADA Eligibility

Valley Transit provides specialized transportation for people with disabilities who are unable to use the fixed route bus system. This service, called Valley Transit II, is administered by Valley Transit and provided under contract by Running, Inc. under the requirements of the Americans with Disabilities Act (ADA). The paratransit eligibility process is also an ADA requirement.

The information obtained in this certification will be used only for the provision of Valley Transit and Valley Transit II transportation services. It may be shared with other transit providers to facilitate travel in their areas, but will not be provided to any other person or agency.

Please type or print.

Personal Information

1. Last name _____ First name _____ M.I. _____

2. Address _____ Gender _____

City _____ County _____ State _____ Zip _____

3. Telephone number(s) (home) _____ (work) _____

4. Date of birth _____ Insurance Provider _____
Insurance ID Number _____

Medical Condition

5.What is the disability that prevents you from using fixed route service?

_____

_____

Is this condition temporary? ☐ Yes ☐ No If "Yes," the expected duration is until ___/___/___

Are you on S.S.I. and/or Medical Assistance? ☐ Yes ☐ No

If "Yes" for Medical Assistance, what is your M.A. number? _____

6. How does this disability prevent you from using fixed route services? Please explain completely. *(If necessary, continue on the back of this sheet.)*

_____

_____

7. Are there any other effects of your disability or other medical conditions of which Occupational Health Systems should be aware? *(If necessary, continue on the back of this sheet.)*

_____

_____

Last name: _____

Mobility Needs

The following information will be used to insure that an appropriate vehicle is used to provide your transportation and that an accurate analysis of your trip requests can be made.

8. Which, if any, of the following aids to mobility do you use? *(Check all that apply.)*

☐ Manual wheelchair ☐ Electric wheelchair ☐ Powered scooter ☐ Walker
☐ Personal care attendant ☐ Guide/attendant animal ☐ Cane ☐ Crutches

9. Do you require a personal care attendant when you use paratransit?

☐ Yes ☐ No ☐ Sometimes

10. Please answer all the following questions:

Can you travel a half block without the assistance of another person?

☐ Yes ☐ No ☐ Sometimes _____

Can you travel ¼ mile without the assistance of another person?

☐ Yes ☐ No ☐ Sometimes _____

Can you travel ¾ mile without the assistance of another person?

☐ Yes ☐ No ☐ Sometimes _____

Can you climb 12-inch steps without assistance?

☐ Yes ☐ No ☐ Sometimes _____

If "Yes," how many in succession? _____

Can you wait outside without support for ten minutes?

☐ Yes ☐ No ☐ Sometimes _____

Emergency Contacts

11. List the names of two people and/or agencies (if appropriate) that may be contacted in case of an emergency.

Name _____ Telephone number(s) _____

Address _____ Relationship _____

Name _____ Telephone number(s) _____

Address _____ Relationship _____

Last name: _____

Additional Contacts & Authorization

12. If this application has been completed by someone other than the person requesting certification, he/she must supply the following information about him/herself.

Name _____

City _____ State _____ Zip _____

Daytime telephone number _____

Signed _____ Date ____/____/____

13. In order for your request to be evaluated, it may be necessary to contact a physician or other professional to confirm the information that you have provided. Please complete the following information and authorization form.

The following (check one) is familiar with my disability and is authorized to provide Occupational Health Systems with the information required to complete this certification.

☐ Physician ☐ Health care professional ☐ Rehabilitation professional

Professional's name _____

Address _____

City _____ State _____ Zip _____

Telephone number _____

I hereby authorize the above professional to provide the required information to Occupational Health Systems. Further, I certify that the information here and on the preceding pages is correct.

Signed _____ Date ____/____/____

IMPORTANT!
This form must be filled out completely and taken to the required certification interview. To schedule an interview, contact Occupational Health Systems of Wisconsin, Inc. at 920-730-5337. It is the responsibility of the applicant to make and keep an interview appointment with a certifier. For more information contact Valley Transit at 920-832-5800.

Completed by Certifier

Certifier's signature _____

Certifier's name (typed or printed) _____

Date(s) of certifier's interview(s) _____

Decision: ☐ I.D. Card # issued _____ ☐ Denied
☐ Referred to review panel

Card class: ☐ Conditional (Tan) ☐ Unconditional (Blue)
☐ Temporary

If the disability is temporary, the expected end date is ___/___/___