

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 St, Dr, Ave, etc.) Apt.# _____
City _____ State _____ Zip _____
3. Telephone Number (Home) _____ (Work) _____
4. Date of birth ____/____/____
5. Male ____ Female ____
6. Emergency Contact Person (Name): _____
Telephone # _____

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7. Please describe the disability which prevents you from using our fixed-route service. _____

Is this condition temporary?

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

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

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

**The following information will be used by the Capital Area
Transportation Authority to assign appropriate vehicles and
schedule your trip.**

10. Do you use any of the following aids for mobility?(Check all that apply):

Manual Wheelchair___ Electric Wheelchair___ Powered Scooter___

Walker___ Cane___ Crutches___ Guide Dog___

Are you able to transfer out of your wheelchair? Yes___ No___

11. Do you require a Personal Care Attendant when you travel using
transit? Yes___ No___ Sometimes_____

12. 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):_____

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

Applicant's Signature _____ Date ___/___/_____

14. 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 for CATA to evaluate your application, it may be necessary to contact a physician or other professional to confirm the information you have provided. Please authorize CATA to contact: (please 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 that is required to complete this certification.

Professional's Name _____

Address _____

City _____ State ___ Zip _____ Phone Number _____

Applicant's signature _____ Date ___/___/_____

Please return to:
The Capital Area Center for Independent Living
1048 Pierpont Dr. Suite 9 & 10
Lansing, MI 48911
Phone: (517) 241-0393 Fax: (517) 241-0438

You will receive a letter telling you the outcome of your certification application request.