

**ATRANS APPLICATION  
FOR  
A.D.A. PARATRANSIT ELIGIBILITY CERTIFICATION**

Information obtained in this certification process will only be used by ATRANS for the provision of transportation services. Information will only be shared with other transit providers to facilitate travel in those areas. The information will not be provided to any other person or agency.

NAME: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_ WORK TELEPHONE NUMBER: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

WHAT IS THE DISABILITY WHICH PREVENTS YOU FROM USING THE FIXED ROUTE SERVICE?

IS THIS CONDITION TEMPORARY?    Yes     No

IF YES, EXPECTED DURATION UNTIL: \_\_\_\_\_

HOW DOES THIS DISABILITY PREVENT YOU FROM USING FIXED ROUTE SERVICES? **(Please explain completely and attach another sheet of paper if more space is needed.)**

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

DO YOU USE ANY OF THE FOLLOWING MOBILITY AIDS? *(Check all that apply)*

POWERED SCOOTER  CRUTCHES  CANE   
MANUAL WHEELCHAIR  ELECTRIC WHEELCHAIR   
PERSONAL CARE ATTENDANT  GUIDE DOG

OTHER (Please specify):

DO YOU REQUIRE A PERSONAL CARE ATTENDANT WHEN YOU TRAVEL? Yes  No

IF YES, NAME OF CERTIFIED PERSONAL CARE ATTENDANT:

CAN YOU TRAVEL 200 FEET WITHOUT THE ASSISTANCE OF ANOTHER PERSON? Yes  No

CAN YOU TRAVEL 1/4 MILE WITHOUT THE ASSISTANCE OF ANOTHER PERSON? Yes  No

CAN YOU TRAVEL WITHOUT THE ASSISTANCE OF ANOTHER PERSON? Yes  No

CAN YOU CLIMB THREE 12 INCH STEPS WITHOUT ASSISTANCE? Yes  No

CAN YOU WAIT OUTSIDE WITHOUT SUPPORT FOR TEN MINUTES? Yes  No

**HEREBY CERTIFY THAT THE INFORMATION GIVEN ABOVE IS CORRECT.**

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**IF THIS APPLICATION HAS BEEN COMPLETED BY SOMEONE OTHER THAN THE PERSON REQUESTING CERTIFICATION, THAT PERSON MUST COMPLETE THE FOLLOWING:**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DAY-TIME TELEPHONE NUMBER: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

**Consent to Contact Physician or other Professional**

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

One of the following listed below is familiar with my disability and is authorized to provide information to the city of Alexandria municipal transit system, ATRANS. *(Please check one)*

Physician       Health Care Professional       Rehabilitation Professional

Please provide the contact information for the professional you have selected above. This information is **required** to complete this certification application.

NAME: \_\_\_\_\_

(Please print)

ADDRESS: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

Please sign and date below to authorize ATRANS to contact physician or other professional.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_