SPORTRAN (Shreveport Transit Management)
CERTIFICATION OF ADA PARATRANSIT ELIGIBILTY

Instructions: PLEASE READ CAREFULLY and remove this sheet before returning application.

Applicants will receive in-person functional assessments as part of the eligibility process. The following information is provided to assist you in completing the attached application for **SporTran OnDemand ADA** service. Please note that eligibility is not based on a person's age. This application is divided into two sections listed below:

Section 1 Applicant Information
Section 2 Health Care Professional Verification

- Be sure the **entire** application is completed clearly in ink, and return **Sections 1 & 2** to **SporTran at the address below**. Incomplete applications will be returned.

- **Section 1** is for applicants to provide demographic information (Identification documents will be verified during the eligibility interview.)

- **Section 2** is to be completed by the health care professional familiar with your disability ONLY. The application will be returned to you if answered by anyone other than the healthcare professional.
  The healthcare professional must be licensed by the state of Louisiana and may include, but is not limited to a physician, nurse, or vocational rehabilitation counselor.

- Signatures are required from all applicants or their legal guardians. Healthcare professionals must include their professional license number and signature.

- For the provision of public transit service, SporTran and the Federal Transit Administration will use the confidential information obtained in this certification. This information will not be provided to any other person.

- Contatc our ADA Coordinator at **(318) 673-5316**, or by email at mobility_ondemand@shreveportla.gov.

Send your completed application to:

SPORTRAN
ADA PARATRANSIT MANAGER
1115 JACK WELLS BOULEVARD
SHREVEPORT, LA 71107

Section 1. Applicant Information. *(To Be Completed by Applicant - Please Print.)*

Last Name_____First _____Middle _____

Cell Phone #_____ Home Phone #_____

Date of Birth _____ Age _____ Email Address _____

Mailing Address _____ State _____ Zip _____

Apartment Name _____

Street Address _____ Apt.# _____

City _____ State _____ Zip _____

Person to contact in case of an emergency:

Name_____ Relationship _____

Street _____

City _____ State _____ Zip _____

Cell Phone # _____ Home Phone # _____

Language Preference: English ☐ Spanish ☐ Braille ☐ Large Print ☐ Audio ☐

Have you ever been certified to use SporTran OnDemand? ☐ **Yes** ☐ **No**

If no, have you ever applied for SporTran OnDemand? ☐ **Yes** ☐ **No**

If yes, give approximate date _____

For Office Use Only

Date Received _____ **I.D.#** _____

Recertification Yes ☐ **No** ☐ **Expiration Date** _____

Category _____ **Eligibility Approved Yes** ☐ **No** ☐ **Date** _____

Section 1 -- continued

1. What type of disabilities prevent you from using SporTran Bus Service?

☐ physical disability ☐ visual impairment/blindness ☐ developmental disability

☐ mental illness ☐ Dialysis Patient ☐ other

Please describe your disability in more detail: _____

_____

_____

2. Is the disability described above temporary or permanent?

☐ Temporary, I expect it to last for another _____ months ☐ Permanent ☐ I don't know

3. Please indicate if you use any of the following mobility aids or equipment (check all that apply.)

☐ cane ☐ long white cane ☐ leg braces ☐ crutches ☐ walker

☐ picture board ☐ alphabet board ☐ manual wheelchair ☐ power wheelchair

☐ powered scooter/cart ☐ service animal (describe): _____ ☐ other _____

☐ portable oxygen ☐ I don't use any of the above aids or equipment

Note: We may not be able to accommodate you on OnDemand or the bus if your wheelchair/scooter is longer than 48 inches or wider than 30 inches, or if the total weight of you and your wheelchair is more than 600 pounds. We will carry the wheelchair and occupant if the lift/ramp and vehicle can accommodate the wheelchair and occupant.

4. Will you travel with your own Personal Care Attendant (PCA)? ☐ **Yes** ☐ **No** ☐ **Sometimes**
(PCA can be a CNA, friend or family member)

5. If you use a wheelchair or scooter, does your residence have a wheelchair ramp? Yes ☐ **No** ☐

If no ramp, how do you transport your wheelchair to street level?

_____

_____

(Driver will not take wheelchair up or down a step to or from your residence or any other facility.)

If necessary, can you transfer yourself from a wheelchair to a passenger seat? Yes ☐ **No** ☐

Section 1 -- continued

6. Please list the three trips you now make or will make most frequent using OnDemand ADA.

SAMPLE

	FROM	**TO (Place or Address)**
1)	*135 Palm Drive 71103*	*Walmart, Airline Dr., Bossier City 71111*

	FROM	**TO (Place or Address)**
1)	_____	_____
2)	_____	_____
3)	_____	_____

NOTE: Travel training is personal (one-on-one) instruction that teaches an individual how to use the SporTran buses.

7. Have you ever had any personal instruction on how to use a SporTran bus?

- ☐ **NO,** I have not received any personal instruction
- ☐ **YES,** I received personal instruction through an agency

  Name of agency: _____
- ☐ **YES,** I received personal instruction from a friend/relative

Indicate below all the skills you learned

- ☐ to travel to and from bus stops ☐ to cross streets
- ☐ to ride on the following routes (please list them):

  Route # _____ Route # _____ Route # _____ Route # _____
- ☐ reading bus schedules and planning trips
- ☐ Other: _____

Did you complete the above-described instruction? ☐ **Yes** ☐ **No**

8. SporTran will be offering free training to anyone interested in learning how to ride the regular buses. Would you be interested in getting information about this service?

☐ **YES** ☐ **NO**

Section 1 -- continued

Please indicate below the reasons why you are seeking OnDemand ADA eligibility (check ONE reason below that best describes your case):

- ☐ Because of my disability, I can NEVER use SporTran bus service, even if I can get to the bus stop and the bus is accessible to those with disabilities.

- ☐ Because of my disability, I could use a lift-equipped SporTran bus I cannot get to or from the bus stop.

I understand the purpose of this evaluation form is to determine if there are times when I cannot use SporTran bus service and must use the OnDemand ADA service. I certify that the information I have given in this application is true and correct. I understand that falsification of information may result in denial of service. I understand all information will be kept confidential and only the information required to provide the services I request will be disclosed to those who perform the services.

Applicant Signature _____ **Date** _____
(Required)

Note:** *Once we have received a completed application (Sections 1 and 2) with all required information,* ***it may take up to 21 days to process it.

Please submit Section 2 to your physician/healthcare professional. This section MUST be completed by a LICENSED HEALTHCARE PROFESSIONAL ONLY.

Section 2

Must be completed by Licensed Health Care Professional – Please type or print

The attached application has been submitted by _____, who has indicated that you are familiar with his/her disability. **The purpose of this form is not to verify the applicant's medical condition, but to verify the effect of his/her medical condition on the ability to get around independently.** ***All questions must be answered for this form to be considered complete*****.** This information will allow SporTran to make a fair evaluation of the applicant's request for Paratransit Services. Thank you for your cooperation.

1. Capacity in which you know the applicant: _____

How does the disability cause a functional limitation that affects this person's ability to get around on his/her own? If the person's ability to get around on his/her own varies in degree at different times, explain the worst-case scenario. Please be specific.

_____

_____

2. Is this condition temporary? ☐ **Yes** ☐ **No**

If Yes, expected duration until: _____

3. If the applicant has a disability affecting mobility, answer the following:

a. Assuming the length of a city block is 500 feet, how many blocks can this person walk without assistance?

☐ 0 Blocks ☐ 1 Block ☐ 2 Blocks ☐ 3 Blocks ☐ 4 Blocks
☐ 5 Blocks ☐ 6 Blocks ☐ 7 Blocks ☐ 8 blocks ☐ 9 Blocks

b. Does this person use mobility aids? ☐ **Yes** ☐ **No** **If Yes, what type (s)?**

☐ Manual Wheelchair ☐ Electric Wheelchair ☐ Power scooter ☐ Crutches
☐ Cane ☐ Walker ☐ Prosthesis ☐ Brace
☐ White Cane ☐ Service animal ☐ Attendant
☐ Other: _____

Section 2 -- continued

Must be completed by Licensed Health Care Professional – Please type or print

☐ 0 Blocks ☐ 1 Block ☐ 2 Blocks ☐ 3 Blocks ☐ 4 Blocks

☐ 5 Blocks ☐ 6 Blocks ☐ 7 Blocks ☐ 8 blocks ☐ 9 Blocks

c. With the use of a mobility aid, how many blocks can the applicant travel independently?

d. How many 7-inch steps (avg. step height) can this person climb without assistance? _____

e. How many 10-inch steps can this person climb without assistance? _____

f. How long can the person wait for a bus at a bus stop?

☐ 10 minutes ☐ 15 minutes ☐ 30 minutes ☐ Other:_____

g. If vision impaired, what is Best Corrected Acuity (Snellen)?

Right eye _____ Left eye _____ Field Restriction: Right _____Left _____

h. Is the individual able to independently maneuver onto and off of a wheelchair lift with or without a mobility aid? ☐ **Yes** ☐ **No**

i. Can this individual read informational signs? ☐ **Yes** ☐ **No**

If No, please explain:_____

_____

j. Can this individual navigate independently? ☐ **Yes** ☐ **No**

If No, please explain: _____

_____

IS THIS PERSON ABLE TO:

k. Give his/her address and telephone number on request? ☐ **Yes** ☐ **No**

l. Recognize landmarks while riding a moving vehicle? ☐ **Yes** ☐ **No**

m. Deal with unexpected situations or unexpected changes in routine? ☐ **Yes** ☐ **No**

n. Ask for, understand and follow directions? ☐ **Yes** ☐ **No**

o. Safely/effectively travel through complex and/or crowded facilities? ☐ **Yes** ☐ **No**

4. If any, what specific weather conditions prevent the individual from getting around on his or her own?

_____

Section 2 -- continued

Must be completed by Health Care Professional – Please type or print

5. Please describe any other functional limitation(s) affecting mobility not described above. Be Specific:

_____

_____

Has this person ever had training to use the city bus service? ☐ **Yes** ☐ **No** ☐ **I don't know**

Could this person use regular city bus service -- if wheelchair accessible?

☐ **Never** ☐ **Sometimes** ☐ **Always**

Could this person benefit from travel training? ☐ **Yes** ☐ **No**

Is their disability: ☐ **Temporary** ☐ **Permanent**

If temporary, how long will applicant need service?_____

All certified applicants are allowed to take a guest with them. Is the applicant required to have a personal care attendant to administer assistance?

☐ **Yes** ☐ **No** (If needed, applicant must provide their own attendant.)

Physician Name, Address, and Telephone

_____/_____

Verifying Physician Name **Area Code + Phone #** **Area Code + FAX #**

_____

Address **City/State** **Zip**

Signature of Verifying Physician _____ **Date** _____

Please provide office stamp below. If you have any additional information, please attach. Thank you for taking the time to complete this application.

Physician Official Stamp

Please return COMPLETED Sections 1 and 2 to SporTran OnDemand for review.