

# CABL

**Community Action Bus Lines**  
**698 Wayne Street**  
**Marietta, Ohio 45750**  
**740-373-7671 Fax 740-373-7398**  
**TDD 1 800 750-0750 Ohio Relay Service**

## **Application** **Certification of ADA Paratransit Eligibility**

Paratransit services are available for eligible disabled riders who live within 3/4 mile from the fixed route and are unable to board the lift equipped CABL bus on the scheduled route.

The information obtained in this certification process will only be used by the Community Action Bus Lines for the provision of transportation services. Information will only be shared with other transit providers to facilitate travel in those areas.

1. Name \_\_\_\_\_

2. Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

3. Telephone Number (Home) \_\_\_\_\_ (work) \_\_\_\_\_

4. Date of Birth \_\_\_/\_\_\_/\_\_\_

5. Do you have a disability that prevents you from using our fixed route service?  
\_\_\_\_\_  
\_\_\_\_\_

Is this a temporary condition? \_\_\_\_\_ If yes, expected duration until \_\_\_/\_\_\_/\_\_\_

6. How does this disability prevent you from using fixed route services? Please explain completely. Use additional sheet if needed.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Are there any other effects of your disability of which we need to be aware? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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 the community Action Bus Lines.**

8. Do you use any of the following aids to mobility? (Check all that apply)

Manual wheelchair \_\_\_ Electric wheelchair \_\_\_ Powered scooter \_\_\_  
Cane \_\_\_ Crutches \_\_\_ Personal care attendant \_\_\_ Service Animal \_\_\_

9. Do you require a Personal Care Attendant when you travel using transit?

YES \_\_\_ NO \_\_\_

10. Please answer the following questions:

Can you travel 200 feet without the assistance of another person?

YES \_\_\_ No \_\_\_ Sometimes \_\_\_\_\_

Can you travel 1/4 mile without the assistance of another person?

YES \_\_\_ NO \_\_\_ Sometimes \_\_\_\_\_

Can you travel without the assistance of another person?

YES \_\_\_ NO \_\_\_ Sometimes \_\_\_\_\_

Can you climb three 12-inch steps without assistance?

YES \_\_\_ NO \_\_\_ Sometimes \_\_\_\_\_

Can you wait outside without support?

YES \_\_\_ NO \_\_\_ Sometimes \_\_\_\_\_

11. In order to allow the Community Action Bus Lines to evaluate your request, it is necessary to contact a health care professional to confirm the information you have provided.

The following Health Care Professional is familiar with my disability and is authorized to provide information to the Community Action Bus Lines required to complete this certification.

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Org/School \_\_\_\_\_

12. I hereby certify that the information provided in this application is correct.

Signed \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

13. If this application has been completed by a caregiver that is authorized to report information, that person must complete the following:

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Daytime Phone \_\_\_\_\_  
Signed \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**\*ALL PARATRANSIT TRIPS MUST BE SCHEDULED  
24 HOURS IN ADVANCE**

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## Medical Provider Certification

Medical Provider Name: \_\_\_\_\_

Applicant Name: \_\_\_\_\_

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

\_\_\_\_\_

Phone #: \_\_\_\_\_

Paratransit services are provided to eligible disabled individuals who are unable to board a lift equipped fixed route CABL bus on the scheduled route. Certification by a medical provider is necessary to confirm the inability of the applicant to use fixed route services.

1) Are you licensed to diagnose a medical condition? Yes or No (Please circle)

2) Does the above-named applicant have a diagnosed disability? Yes or No (Please circle)

Is this disability temporary? \_\_\_\_\_

If yes, expected duration until \_\_\_/\_\_\_/\_\_\_

3) Which of the following circumstances affect the applicant that makes them unable to utilize the current fixed route services offered by CABL? (Please circle)

A. *Applicant has a mobility impairment that makes it impossible to travel to a street corner on a fixed route and be picked up by a lift equipped CABL bus.*

B. *Applicant cannot wait unassisted to be picked up by a lift equipped CABL bus.*

C. *Other (please specify)* \_\_\_\_\_

\_\_\_\_\_

4) How far can the above applicant travel without the assistance of another person? \_\_\_\_\_  
(ex. 1 city block, ¼ mile, 200 feet, etc.)

By signing below, I hereby certify that the above information is correct and that it is my medical opinion that above-named applicant does have a disability that makes them unable to utilize the fixed route services offered by CABL Bus Lines.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date