

Application Form
Certification of ADA Paratransit Eligibility
Bloomington-Normal Public Transit System

This application form is used by BNPTS to determine an individual with disabilities eligibility for BNPTS Special Service buses.

If you have any questions, please contact us at the address listed below.

Send completed applications to:

BNPTS

351 Wylie Drive

Normal, IL 61761

Special Services: (309) 828-7511

Fax: (309) 828-1952

Please answer all of the questions. An incomplete application will be returned. The applicant will receive, by mail, a written determination of acceptance or denial of eligibility within 21 days following receipt of a completed application and verification.

1) Last Name _____

First Name _____ Middle Initial _____

2) Address _____

City _____ State _____ Zip _____

3) Daytime Phone _____ Evening Phone _____

4) Applicant's Date of Birth ____/____/____

5) List the name of one person or agency that we may contact in the event of an emergency.

Name: _____

Address: _____

Phone Number: _____

6) Do you have a physical or mental impairment?

Physical _____ Mental _____ Both _____

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7) What is your disability? _____

8) Is this condition temporary? Yes _____ No _____

If Yes, what is the expected duration? _____ / _____ / _____

9) To utilize fixed routes you may need to travel up to 1/4 mile to the bus stop, wait outside for up to 10 minutes, climb 3 steps into the bus or use the passenger lift, and be able to navigate the system (recognize destinations, understand transfers, and distinguish between vehicles).

Does this disability prevent you from using BNPTS fixed route bus services independently?

Yes _____ No _____ Sometimes _____

If you answered "No" to question 9, skip ahead to number 21

10) How does this disability prevent you from using BNPTS fixed route services? Please explain completely. If you answered "sometimes" to question 9, explain the circumstances. Use an additional sheet if necessary.

11) Are there any other effects of your disability of which we need to be aware?

12) Do you require a Personal Care Attendant to assist you when you are travelling?
Yes _____ No _____ Sometimes (explain) _____

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

<input type="checkbox"/> Electric Wheelchair	<input type="checkbox"/> Cane
<input type="checkbox"/> Manual Wheelchair	<input type="checkbox"/> Crutches
<input type="checkbox"/> Scooter	<input type="checkbox"/> Service Animal
<input type="checkbox"/> Walker	
<input type="checkbox"/> Life Support Equipment: _____	
<input type="checkbox"/> Other: _____	

14) Does temperature or weather affect your disability?

Yes _____ No _____

If yes, what temperatures or weather and how do they limit you?

15) Does your disability effect your mobility?

Yes _____ No _____ Sometimes _____

16) Can you travel the following distance outside without the assistance of another person? Travel includes using mobility aids. (If you mark "sometimes", please explain.)

200 feet (about 1/2 block)

Yes _____ No _____ Sometimes _____

400 feet (about 1 block)

Yes _____ No _____ Sometimes _____

800 feet (about 2 blocks)

Yes _____ No _____ Sometimes _____

1/4 mile (about 3 blocks)

Yes _____ No _____ Sometimes _____

3/4 mile (about 9 blocks)

Yes _____ No _____ Sometimes _____

17) Can you climb steps without assistance?

One 12 inch step Yes _____ No _____ Sometimes _____

Three 12 inch steps Yes _____ No _____ Sometimes _____

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18) Can you wait outside without support for 10 minutes?
Yes _____ No _____ Sometimes _____

19) Are you sight impaired or legally blind?
Yes _____ No _____ Sometimes _____

20) Are you able to:
give addresses and telephone numbers upon request?
Yes _____ No _____ Sometimes _____

recognize a destination or landmark?
Yes _____ No _____ Sometimes _____

deal with unexpected situations or unexpected change in route?
Yes _____ No _____ Sometimes _____

ask for, understand, and follow directions?
Yes _____ No _____ Sometimes _____

safely and effectively travel through crowded and/or complex facilities?
Yes _____ No _____ Sometimes _____

21) I hereby certify that the information given above is correct.

Signed _____ Date _____ / _____ / _____

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 _____

Telephone Number (home) _____ (work) _____

Signed _____ Date _____ / _____ / _____

Authorization Form

In order to allow BNPTS to evaluate your request for certification for Special Services, it may be necessary for us to contact a physician or other professional to confirm the the information that you have provided. Please complete the following information and authorization form and return it with your application.

The person listed below is familiar with my disability and is authorized to provide information to the Bloomington-Normal Public Transit System required to determine my qualifications for special transportation services.

Fill in the following information on a Physician or
Professional who is familiar with your disability.
Please Print

The individual listed below is a:

- _____ Physician
- _____ Health Care Professional
- _____ Rehabilitation Professional
- _____ Social Service Agency Representative

Physician's Name _____

Address _____

City _____ State _____ Zip _____

Telephone Number _____

Applicant's Name _____

Applicant's Date of Birth ____/____/____

_____ Date ____/____/____

Signature of Applicant

NOTE: Any medical fees associated with providing this information is the responsibility of the applicant or client and not of the Bloomington-Normal Public Transit System.