ROBERT G. CASSILLY
Harford County Executive

ROBERT S. MCCORD
Director of Administration

BARBARA W. RICHARDSON
Director of Housing &
Community Services

Dear Applicant:

If you would like to apply for the first time or recertify for a Harford Transit LINK Mobility (Demand Response or ADA Complimentary Paratransit) service, you must complete the following steps:

1. Read and follow the directions in the application. Complete Part I, II, and III of the Application and have one of the health care professionals treating you, listed on the application, complete Part IV. **Please note that Page 6 in Part II must be signed and dated by the applicant and Page 9 in Part IV must be signed and dated by the health care professional treating you.**
2. When all questions in Parts I-IV are complete:
   - Option 1: Mail your application (Parts I-IV) to ATTN: Harford Transit LINK, Dispatch Office, 1311 Abingdon Road, Abingdon, MD 21009
   - Option 2: Fax your application (Parts I-IV) to 410-679-7346
   - Option 3: Email your application (Parts I-IV) to hcts@harfordcountymd.gov
3. Once your application is received, a member of our team may call you on the phone number listed on your application for further information.

Harford Transit LINK has up to twenty-one (21) days to make a determination. If a determination has not been made within 21 days, you will be granted presumptive eligibility until a decision on your eligibility can be made. If it is determined you are not eligible or conditionally eligible for Mobility service, the determination letter will provide you with the details on how to appeal the decision. You have sixty (60) days to appeal a determination.

You can obtain information about the appeal process or other information about our Mobility service by visiting our website at www.HarfordTransitLINK.org.

If you have any questions, please contact the Dispatch Office at 410-612-1620 and select option 1.

Thank you,

Dispatch Customer Service Team

Harford Transit LINK ADA Transportation Application

In compliance with the American Disabilities Act (ADA), Harford Transit LINK provides a shared ride, advanced reservation, origin to destination service for disabled individuals who are unable to use regular fixed route public transportation services because of their disabilities.

To be eligible for service, the functional limitations of an individual's disability must prevent use of regular fixed route buses. **Paratransit service is not available to persons who find it uncomfortable or difficult to get to and from bus stops.**

Please be aware that Harford Transit LINK provides two types of public transportation:

1. **Fixed Route** buses provide service at designated bus stops along specific routes according to set schedules. Many fixed route buses have features to make riding easier for people with disabilities, including wheelchair lifts and handrails for entering and exiting the bus.
2. **Paratransit Service** is a shared ride, advanced registration, origin to destination public transportation service for people whose disability prevents them from riding fixed route buses. You must receive certified approval to use this service and must call in advance to make a reservation to travel.

Applications MUST BE CERTIFIED by a licensed or certified health care physician who is providing treatment every 5 years and within 30 days of expiration.

Your ability to ride fixed route buses will be evaluated through use of this application, and in some circumstances, an in-person interview. Each application will be evaluated on a case-by-case basis, taking into consideration all of the information provided.

Applications are processed in the order in which they are received. A determination will be made within 21 days of receipt of the application and you will be notified of this decision in writing.

It is critical that the application be filled out completely.
Incomplete and illegible applications will not be processed and will be returned. Applications must have original signatures, as faxed or photocopied signatures are not permitted.

If you have any questions concerning this application or paratransit services, please contact the ADA operations supervisor at 410-612-1620 ext. 1.

Please submit completed ADA applications to: Harford Transit LINK
1311 Abingdon Road
Abingdon, MD 21009

For Office Use Only

ID#:_____ Expiration Date: _____

(Circle) Approved / Denied by: _____

Date: _____

ADA Transportation Application — Part I: General Information

Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street Address) (Apt or Building #)

_____
(City) (State) (Zip Code) (County)

Mailing Address (if different): _____
(Street Address) (Apt or Building #)

_____
(City) (State) (Zip Code) (County)

Phone:_____ Mobile Phone: _____

SSN (last 4 digits): _____ Date of Birth: _____

Emergency Contact

Name: _____ Relationship: _____

Phone:_____ Mobile Phone: _____

Please select what you are applying for: ☐ ADA/Paratransit ☐ Reduced Fare only

Are you a customer of another Paratransit system? ☐ No ☐ Yes: _____
(Name of System)

1. **Please check all applicable boxes of mobility aids or equipment you currently use.**

☐ Walking Cane	☐ Walker	☐ Powered Scooter/Cart
☐ Orthopedic Cane (3-4 Prong)	☐ Leg Braces	☐ Respirator/Oxygen Tank
☐ Long White Cane (Vision Impaired)	☐ Manual Wheelchair	☐ Other
☐ Service/Guide Animal	☐ Powered Wheelchair	☐ None

2. **Have you ever used our fixed route services?**
   - ☐ Yes, I typically ride _____ times a week
   - ☐ Yes previously, but I stopped because: _____
   - ☐ No, I have never used Harford Transit LINK's fixed route services
   - ☐ No, but I would be interested in learning how to use your regular service

3. **How far from your home is the nearest bus stop? (1 block = 440 ft)**
   - ☐ Less than 1 block ☐ 1-2 blocks ☐ 3-4 blocks
   - ☐ 5 or more blocks ☐ I do not know

4. **On your own, or using your assistive device, how far can you travel on level ground?**
   - ☐ I can get to the curb in front of my house/apartment ☐ I can travel up to 3 blocks (1/4 mile)
   - ☐ I can travel up to 6 blocks (1/2 mile) ☐ I can travel up to 9 blocks (3/4 mile)

5. **WITHOUT the help of someone else, can you:**

Ask for, understand, and follow written or spoken instructions: ☐ Yes ☐ No ☐ Sometimes
If sometimes, please explain: _____

Cross the street, either on your own or with an assistive device: ☐ Yes ☐ No ☐ Sometimes
If sometimes, please explain: _____

Stand for 30 minutes if there is no place to sit: ☐ Yes ☐ No ☐ Sometimes
If sometimes, please explain: _____

Step on and off a sidewalk from the curb: ☐ Yes ☐ No ☐ Sometimes
If sometimes, please explain: _____

Walk up and down three steps if there is a handrail: ☐ Yes ☐ No ☐ Sometimes
If sometimes, please explain: _____

Stand on a moving bus if holding onto a handrail: ☐ Yes ☐ No ☐ Sometimes
If sometimes, please explain: _____

6. **Explain how your disability prevents you from using Harford Transit LINK's fixed route services:**
   Failure to provide answer will result in application processing delays or denial.

I certify to the best of my knowledge and ability, the information in this application is true and correct. I hereby authorize permission to the licensed health care professional treating me to release any relevant information for the purpose of evaluating my eligibility to use paratransit services.

I understand that approval of this certification will be for a term of 5 years and it is my responsibility to initiate recertification within 30 days of expiration.

Applicant Signature: _____ Date: _____

If this application was completed for you by another person, please provide the following information.

Name: _____ Contact Number: _____

Address: _____

Agency or Clinic (if applicable): _____

Relationship to Applicant: _____

Signature: _____ Date: _____

This portion MUST BE COMPLETED by a licensed or certified health care professional who is providing treatment

The Americans with Disabilities Act of 1990 (ADA) requires the provision of paratransit service to **anyone who is prevented from using the regular transit system, by reason of physical or mental limitation, and who is traveling in an area served by the system.**

The applicant who has asked you to review and sign this form is seeking eligibility for Paratransit Specialized Transportation service. This application is intended to determine whether applicant can use regular transit ser- vices or whether he/she requires origin to destination service.

Resources for this program are limited so please exercise care in evaluating this applicant. Your evaluation must be based solely on the applicant's ability to use regular transit services. False verification could result in travel limitations for persons legitimately qualified for this program.

Please carefully review the information provided by the applicant and answer the questions below.

Name of Applicant: _____

1. **Please mark all disabilities which prevent the applicant from using fixed route bus services.** ***Conditions that make it difficult or uncomfortable should not be checked.***

Neuromuscular		
☐ Arthritis	☐ Muscular Dystrophy	☐ Quadriplegia
☐ Amputation	☐ Paraplegia	☐ Spina Bifida
☐ Cerebral Palsy	☐ Parkinson's Disease	☐ Stroke/Brain Injury
☐ Multiple Sclerosis	☐ Polio	☐ Other: _____

Cardiovascular/Respiratory		
☐ Arteriosclerosis	☐ Congestive Heart Failure	☐ Thrombosis (Chronic)
☐ Asthma	☐ Emphysema	☐ Other: _____
☐ Chronic Obstructive Pulmonary	☐ Heart Attack	
☐ Cystic Fibrosis	☐ Peripheral Vascular Disease	

Cognitive/Psychological		
☐ Alzheimer's Disease	☐ Head Trauma	☐ Schizophrenia
☐ Autism	☐ Panic Disorder	☐ Other: _____
☐ Dementia	☐ Phobia	

{continued, directions on previous page)

General Medical		
☐ AIDS	☐ Epilepsy (Severe)	☐ Skin Disorder
☐ Cancer	☐ Kidney Disease	☐ Other: _____
☐ Diabetes (Severe)	☐ Lupus	

General Medical					
Cataracts	☐ One	☐ Both	Retinal Detachment	☐ One	☐ Both
Glaucoma	☐ One	☐ Both	Retinopathy	☐ One	☐ Both
Legally Blind	☐ One	☐ Both	Totally Blind	☐ One	☐ Both
Macular Degeneration	☐ One	☐ Both	OTHER: _____		

2. What disability <u>prevents the applicant from riding the regular bus system</u>? A detailed diagnosis is required. Please be as specific as possible without using diagnostic codes.

3. Describe how this disability affects the applicant's functional ability to ride the regular bus system:

4. Is this condition permanent or temporary? If temporary, what is the expected duration?

5. Does the applicant's disability require them to travel with an attendant?

☐ Yes ☐ No ☐ Sometimes *(please provide specific situations)*

6. **Is the applicant able to travel to and from a bus stop?** ☐ Yes ☐ No *(if no, indicate all that apply):*

   ☐ Cannot negotiate if the street or sidewalk is too steep.

   ☐ Cannot travel if there are no curb cuts.

   ☐ Cannot cross busy streets and intersections.

   ☐ Cannot tolerate extreme temperatures.

   ☐ Cannot locate bus stop due to a visual impairment.

   ☐ Cannot wait outside without support for 15 minutes.

   ☐ Becomes confused easily and may get lost

   ☐ Other: _____

7. **Indicate the individual's ability to independently perform the following functions using the most effective mobility aid.**

	Little to no difficulty	**Discomfort and some difficulty**	**Severe pain and difficulty**	**Impossible & likely to cause medical crisis**
Find own way home between familiar locations				
Handle money or tickets				
Provide address & telephone numbers upon request				
Recognize a destination or landmark				
Ask for, understand, & follow directions				
Travel 200 feet (city block)				
Travel 1/4 mile (three blocks)				
Deal with unexpected situations or unexpected changes in routine				
Safely & effectively travel through crowds & complex facilities				

Applications with illegible or incomplete information will be returned.
Please use medical office stamp if available.

Person Completing Certification: _____

Professional Title: _____

License/Certification #: _____

Business Address: _____

Clinic or Agency: _____

Business Telephone: _____

I verify that the information provided for verification is true and correct.

_____	_____	_____
(Signature)	(Printed Name)	(Date)