RETURN

Connecticut Americans with Disabilities Paratransit Application Form

This form is also available online at www.CTADA.com

Please note that any information given on this application will be kept confidential and shared only with professionals involved in providing the paratransit service on an as needed basis.

THIS APPLICATION WILL BE ACCEPTED AT ANY ADA PARATRANSIT PROVIDER IN THE STATE OF CONNECTICUT

A. Personal Information			
Mr. ☐	Mrs. ☐	Ms. ☐	Date of Birth: / /
Last Name:		First Name:	

B. Current Residence		
Street Address:		
Building #:	Apartment #:	Room #:
City:	State:	Zip:
Is this residence:		
☐ A Single or Multi-Family House		
☐ An Apartment or Condominium Complex	Name:	
☐ A Nursing or Assisted Living Facility	Name:	
☐ Other:		
Is this a temporary residence:	Yes ☐	No ☐

C. Mailing Address (if different from residence)		
Street Address or P.O. Box:		
Building #:	Apartment #:	Room #:
City:	State:	Zip:

D. Contact Information

Primary Phone:	**Alternate Phone:**
TDD or Relay Number:	
Email Address:	

E. Emergency Contact

Last Name:	**First Name:**
Relationship:	**Agency if Applicable:**
Primary Phone:	**Alternate Phone:**

F. If someone assisted you in completing this form please give the following information:

Last Name:	**First Name:**
Relationship:	**Agency if Applicable:**
Primary Phone:	**Alternate Phone:**

G. General Information

Do you need ADA service information in an accessible format? Yes ☐ No ☐

If "yes", please indicate which format would be helpful:

	Large Print ☐	**Audio Recording** ☐	**Braille** ☐

Other _____

Are you certified for ADA paratransit services by another service provider or transit agency? Yes ☐ No ☐

If, yes:	**Name of Service Provider:**	**State:**	**ID #:** (if applicable)

H. Information About Your Disability

Please list by name what disabilities or health related conditions prevent you from using the public bus service:

Explain how your disabilities or health related conditions prevent you from independently using the public bus service?

Do you use any of the following when you travel?

☐ Manual Wheelchair *	☐ Scooter *
☐ Powered Wheelchair *	☐ Cane
☐ Walker	☐ Communication Device
☐ Oxygen If yes:	☐ Crutches
☐ Tank ☐ Compressor	☐ Service Animal
☐ Respirator	☐ Medical Equipment
☐ Other, explain:	

*The term wheelchair refers to any three or more wheeled device utilized which is usable indoors. We will be able to accommodate a wheelchair if (1) the lift and vehicle can physically accommodate it and (2) if it is consistent with legitimate safety requirements. Legitimate safety requirements include but are not limited to such circumstances as a wheelchair of such size that it would block an aisle, or would interfere with the safe evacuation of passengers in an emergency.

H. Information About Your Disability (continued)

Is the disability or health related condition you describe:

Permanent ☐	
Temporary ☐	Expected to last _____ Months
Unsure ☐	

Does your health condition or disability change from day to day in a way that affects your ability to use the public bus service?

Yes ☐	No ☐	Sometimes ☐

If "Yes", Please explain:

Are there times when someone accompanies you when you travel?

Yes ☐	No ☐	Sometimes ☐

I. Public Bus Service Experience

Do you ride the public bus? Have you ever ridden the public bus?

Yes ☐	If yes, how often and to what locations?
No ☐	If no, why don't you currently ride the public bus?

Travel training is a free service that teaches people how to use the public bus. Would you like more information about this service?

Yes ☐	No ☐	

J. Functional Ability

Can you find your way to a public bus stop if someone shows you once?		
Yes ☐	No ☐	Sometimes ☐
How far can you walk (using a mobility aid if necessary)?		
Can you walk up/down a gradual hill?		
Yes ☐	No ☐	Sometimes ☐
Can you see/detect curbs, ramps and other drop off areas?		
Yes ☐	No ☐	Sometimes ☐
How long can you stand and wait at a public bus stop?		
Can you get on and off a public bus?		
Yes ☐	No ☐	Sometimes ☐
If "no" please explain:		
Can you ask for, understand, and follow travel directions.		
Yes ☐	No ☐	Sometimes ☐

K. Barriers

What barriers in the environment would make it difficult for you to use the public bus service?	
☐ Lack of curb cuts	☐ Steep Hills
☐ Busy street I must cross	☐ No crosswalk light
☐ No sidewalks	☐ Sidewalks in poor condition
☐ Other, describe:	
Explain why the conditions you indicated make it difficult to use the public bus service	

MILFORD TRANSIT
DISTRICT
259 Research Drive
Milford, CT 06460
Tel. 203-874-4507

Henry D. Jadach
Executive Director

City of Milford, Connecticut

Founded 1639

AUTHORIZATION TO RELEASE CONFIDENTIONAL INFORMATION

DATE: _____

_____
NAME DATE OF BIRTH

_____
ADDRESS CITY STATE ZIP

I AUTHORIZE MILFORD TRANSIT TO RELEASE INFORMATION REGARDING THE BASIS FOR MY ELIGIBILITY FOR ADA PARATRANIT TO:

_____
NAME OF AGENCY

_____
ADDRESS CITY STATE ZIP

THIS RELEASE IF VALID UNTIL _____ AND WILL NOT BE FURTHER TRANSFERRED WITHOUT ADDITIONAL AUTHORIZATION.

_____
RIDER'S SIGNATURE DATE

File:MW:ADAMaterial:Releaseform

Household Certification Form

Homeowner/Applicant Name:	[ ] Male [ ] Female
Co-Homeowner/Applicant Name:	[ ] Male [ ] Female
Number of Person(s) in the Household: [ ]	Number of Children under the Age of 18: [ ]
Number of Persons 62 years of Age or Older: [ ]	Household with Disabled Person: [ ]

Please Provide Household Race/Ethnicity (*Check one per household*).

[ ] White
[ ] Black
[ ] Asian/Pacific Islander
[ ] American Indian/Alaskan Native
[ ] Asian White
[ ] Black/African American & White
[ ] Other Multi-Racial
[ ] Hispanic
[ ] Hispanic, White
[ ] Hispanic, Black
[ ] American Indian/Alaskan Native & Black/African American
[ ] Asian/Pacific Islander
[ ] Native Hawaiian/Other Pacific Islander

Household Income

Please provide name and the annual adjusted gross income (AGI) of each household member *over the age of 18*. Further income verification from household members over the age of 18 may be required. (If more space is needed please use back of this form)

Household Member Name	Relationship	Annual Income(AGI)	Student Status
		$	F/T__ or P/T __
		$	F/T__ or P/T __
		$	F/T__ or P/T __
		$	F/T__ or P/T __
		$	F/T__ or P/T __
		$	F/T__ or P/T __
		$	F/T__ or P/T __
Household Income (Office Only)		$	

CERTIFICATION:

I/We hereby certify that the information on this form is complete and correct to the best of my knowledge.

Homeowner/ Applicant Signature _____ Date _____

Co-Homeowner/Applicant Signature _____ Date _____

This information is required to receive Federal funds to assist this organization to continue to offer this program or activity. The information on this form is confidential and will not be shared with an agency other than the Grantor, the Department of Community Development, which regulates use of Community Development Block Grant funds for the City of Milford. This information is used to determine program eligibility and the statistical information of the participant to ensure that CDBG funds assist low and moderate-income individuals and families.

DO NOT SIGN THIS PAGE NOW OR SUBMIT WITH YOUR APPLICATION.

THIS PAGE MUST BE SIGNED IN PERSON AT THE INTERVIEW.

I understand that the purpose of this application is to determine if there are times when I cannot use the public bus service and must therefore use ADA paratransit services. I certify that to the best of my knowledge, the information in this application is true and correct. I understand that providing false or misleading information may result in a reevaluation of my eligibility.

_____ ____/____/____

Signature of Applicant or Guardian **Date**

PLEASE NOTE:

After receiving the completed application you will be contacted by the transit agency to schedule a face-to-face interview.

The service provider has 21 days in which to make an eligibility determination after all necessary documentation is received, which includes face to face interviews. It also may include information requested from an appropriate medical or rehabilitative professional familiar with your disability.