SPACE COAST Area Transit

ADA PARATRANSIT CERTIFICATION FORM

ADA Paratransit serves points of origin and destination within 3/4 of a mile of Space Coast Area Transit's Fixed Route Service, covering most of Brevard County from Titusville to Palm Bay. The ADA Certification Form details how an individual's disability prevents them from using the Fixed Route Bus System and determines their eligibility. The form may be completed by the applicant or by a qualified professional who knows the applicant's condition. If the applicant completes the form, Section 3, Request For Professional Verification must also be filled out. Applications are available in Braille, large type, and on tape upon request.

Applicants are eligible for 21 days of service while their ADA Eligibility Certification Form is being processed. Additionally, they are eligible for 21 days of out-of-town service if they have ADA Paratransit Certification from another public entity. Once an applicant's ADA Paratransit eligibility is certified, an ADA Eligibility Card and ride-reservation information will be mailed to the applicant within 4 weeks of the date their form was received. The ADA Eligibility Card will be valid for 3 years from the issue date. If eligibility is denied, a letter will be mailed to the applicant explaining the reason for denial and the process to appeal.

Applicants **MUST** include the following to prove eligibility: a Medicare Card, SSD Letter, SSI Award Letter, or a letter from a medical provider, **plus** a State ID. Complete/submit the ADA Application online and upload your required documents electronically at **321Transit.com/ADAapply**, or complete/submit the ADA Application manually and return the **signed** application along with your documents to Space Coast Area Transit, 401 South Varr Ave., Cocoa, FL, 32922. For questions, assistance in filling out the application, or to schedule initial service, contact Customer Service at (321) 635-7815 ext. 52937 or email **info@321Transit.com.**

SECTION 1 - PERSONAL INFORMATION

Last name: First Name: Middle Initial:

Email: Date of Birth: Male: Female:

Home Phone: Work: Mobile:

Home address: City:

Sub Division Name: State: Zip:

Mailing Address (if Different):

Emergency Contact: Relationship:

Contact's Home #: Work: Mobile:

Explain nature of disability preventing applicant from using Fixed Route Bus Service:

Is this condition temporary? Yes No If Yes, expected time of duration:

Completely explain how disability prevents applicant from using Fixed Route Service:

Completely explain other relevant effects of applicant's disability:

SECTION 2 - ANALYZATION OF VEHICLE REQUIREMENTS

Check any of the following mobility aids that are applicable to the applicant:

- ☐ Manual Wheelchair
- ☐ Electric Wheelchair
- ☐ Cane
- ☐ Powered Scooter
- ☐ Service Animal
- ☐ Oxygen Tank Personal
- ☐ Crutches
- ☐ Walker
- ☐ Care Attendant

Requires personal care attendant to travel via transit	☐ Yes	☐ No
Can walk 200 feet without assistance of another person	☐ Yes	☐ No
Can travel ¼ mile without assistance of another person	☐ Yes	☐ No
Can climb four (4) 12-inch steps without assistance of another	☐ Yes	☐ No
Can wait outside without support for 10 minutes	☐ Yes	☐ No

I certify that the information above is true and accurate:

Applicant's Signature _____ Date _____

If application was completed by a person other than the applicant:

Name: _____ Relationship: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Signature _____ Date _____

SECTION 3 - REQUEST FOR PROFESSIONAL VERIFICATION

In order to confrm eligibility, it may be necessary for Space Coast Area Transit to contact the applicant's healthcare professional. Please complete the following authorization form.

☐ Physician ☐ Rehabilitation Professional ☐ Other If other: _____

is familiar with my disability and is authorized to provide information to Space Coast Area Transit required to complete this certifcation.

Health Care Professional Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Applicant's Signature _____ Date _____

Only signed applications with a copy of State ID and proof of disability will be processed.

SECTION 4: FOR OFFICE USE ONLY – REVIEW RESULTS

Date Received: _____ New Application: (Y/N) Redetermination: _____

Reviewed by: _____ Date Approved: _____ Date Denied: _____

Reason for Denial: _____ Letter: _____ Category Type: _____