Rider's Name:

Phone No:

Caller Box 10007
Saipan, MP 96950
Telephone: 670-664-2682
Fax: 670-664-2692
Email: cnmicota@gmail.com

COTA use only		
Received by:		
Date Received:		
	Approved	Disapproved
Date		
Initials		

Commonwealth Office of Transit Authority

Application for Eligibility of ADA Paratransit Services

March 2018

If you are 55 years of age or older, believe you have a disability, or a US Military Veteran

... *that prevents you from using regular transportation, please complete this application and return to the address above to determine your eligibility to receive*

ADA Paratransit services

The Federal Americans with Disabilities Act (ADA) requires comparable public transportation services for person with disabilities who are unable, because of their disability to use a regular transportation.

If you believe you have a disability that prevents you from using the regular public transportation, please complete this application and return it to the address below to determine your eligibility.

It is important that all parts of this application are completed. **You, the applicant, are responsible for the completing the entire application form.**

- COTA will review your application and follow-up as necessary to determine you eligibility for paratransit series.
- COTA will notify you within 15 days of receiving your completed application regarding your eligibility for paratransit services.

If you have not received a determination after 15 days of submitting your application, please call (670) 664-2682. If you are denied eligibility, you have a right to appeal the eligibility decision. Please contact COTA on the appeals process.

PLEASE SEND COMPLETED APPLICATIONS TO: COTA, Caller Box 10007. Saipan, MP 96950.

If you have questions regarding the eligibility application process, ADA Paratransit Service, or other transit matter, please call (670) 664 – 2682, fax 670-664-2692, send email to cnmicota@cota.gov.mp or visit our website at http://www.cota.gov.mp.

Commonwealth Office of Transit Authority

Application of ADA Paratransit Service Eligibility

☐ First Time Applying ☐ Renewal ☐ Re-Applying

SECTION 1 : Personal Information

Check 1: ☐ Mr. ☐ Mrs. ☐ Miss. ☐ Other__________ (Dr./Rev.,etc)

Name: ______________ ____________________ _____________________

Last First Middle Initial

Mailing Address ___________________ __________ __________ ______________

Address City State Zip Code

Residence Address: _______________ _______________ ______________________

Village Street House/Apt.#

Date of Birth:__________(mm/dd/yy)

Phone: (H): ___________________ (W): _____________________ (Cell): _____________________

Email Address:

____

Emergency Contact:

Name: ___________________ Relationship: ___________________ Contact Number: __________________

1. Please describe your disability and explain in detail how it prevents you from using regular transportation: ____
____
____

2. My condition is: ☐ Permanent ☐ Long-Term ☐ Temporary _______________
(Expected duration)

3. Are there any other conditions that limit your ability to use the COTA Van? Yes or No.

If yes, please explain: ____
____
____

SECTION 2: Mobility Information

Mobility: (Please check all that apply)

☐ Uses Cane ☐ Uses Walker ☐ Uses Crutches ☐ Uses a Service Animal
☐ Need to use lift instead of steps ☐ Requires Portable Oxygen ☐ Other____________

Wheelchair: ☐ Manual ☐ Motorized ☐ Multi-Wheel Scooter Length/Width: ______

1. Using mobility aid or on your own, how many blocks can you walk on level ground (estimate 1 block = 500 feet)? Number of Blocks:___________________________

2. Do you require a Personal Care Attendant (PCA) or escort to accompany you when you travel? Yes ☐ No ☐

3. If you checked **YES,** please list the name(s) of your PCA (agency or escort):

   Name: __________________Address:_______________Telephone: ____________

   Name:___________________Address:_______________Telephone: ____________

   Name:___________________Address:_______________Telephone: _____________

4. Does your disability prevent you from getting to or from your house to your driveway?
   Yes☐ No☐ if **YES,** please explain: (**MUST COMPLETE**)
   ____
   ____
   ____

5. Can you climb three (3) steps without assistance?☐Yes ☐ No If **NO,** please explain:
   ____
   ____

6. Is your ability to travel or to wait outdoor affected by extreme hot or cold weather conditions? ☐Yes ☐ No If **YES,** please describe conditions you cannot tolerate.
   ____
   ____
   ____
   ____

COMMONWEALTH TRANSIT AUTHORITY

7. Are you able to board or disembark from a COTA vehicle with a wheelchair lift?

   Yes☐ No ☐ If **NO,** please explain:

   ____
   ____
   ____

8. Are you able to get around independently without assistance?
   Yes☐ No ☐ If **NO,** please explain:

   ____
   ____
   ____

9. Are you able to ask for, understand and follow directions?
   Yes☐ No ☐ If **NO,** please explain:

   ____
   ____
   ____

In order for COTA to evaluate your application, it is necessary to contact a healthcare professional to verify the information that you have provided. Your signature on the following page will provide the authorization.

Please list the names of a health care professional (licensed physician, therapist, social worker, or nurse, or certified or registered specialist) designated by the applicant, who may be contacted by COTA.

Name of Health Care Professional: ____

Office/Mailing Address:____

City _____________ State __________ Zip Code ___________Telephone___________

I hereby certify that the information provided in this application is correct. I authorize the release of information and photos to the Commonwealth Office of Transit Authority (COTA). I also authorize COTA to contact the health care professional who completed Section 3 of this section to release information regarding my disability to COTA. The information about my disability will be used solely to determine my eligibility for paratransit services.

Print, Sign, and Date: ____

If you are not the applicant but have completed this application on the applicant's behalf, you must provide the following information:

Full name (Print):_______________________________ Telephone: ______________________

Mailing Address: _________________City: _________ State__________ Zip Code: ________

Relationship to Applicant: ____

I hereby verify that to the best of my knowledge the information given above is correct and can be verified by the applicant's health care professional.

Signature: __________________ Date________________ (mm/dd/yyy)

Please give directions and draw a map to your residence in this space.

If you are 55 years old or older please stop here and submit the completed application to COTA

FOR United States MILITARY VETERANS

Please provide a copy of a valid DD FORM 214 for proof of veteran status and another valid ID.

You have now completed the applicant section of the ADA Paratransit Eligibility Form. Please give this entire Application to the Health Care Professional most familiar with your abilities and disabilities

Section 3: Health care – Professional Verification

VERIFICATION OF PARATRANSIT ELIGIBILITY

Health Care Professional Verification of Applicant's Disability and Functional Capabilities
This portion of the application form is to be completed by a Health Care Professional, who is familiar with the applicant's abilities and disabilities, as they relate to their abilities to travel about the community.

The attached applicant has applied for ADA Paratransit Service with the Commonwealth Office of Transportation Authority (COTA). You are being asked to provide information regarding this applicant's disability as it affects their ability to use the regular transportation to move about the community. Please note that all of our vans are lift-equipped for individuals who use wheelchairs, scooters or unable to use the steps. COTA provided the paratransit (Curb-to-Curb) service to people who cannot use regular transportation. Not all persons with disabilities qualify for paratransit services.

Please assist our office in determining the eligibility state of ___________________________. By reviewing the enclosed application and completing the attached verification of paratransit eligibility form. If you have any questions regarding ADA Paratransit eligibility, please contact the COTA at (670-664-2682).

I have reviewed the enclosed application and I Agree/Disagree with the information provided. If you circled disagree, please explain why:

The applicant is unable to use the regular transportation because:

Temporary: Expected duration until _____________________ (mm/dd/yyyy)
Long Term: Conditions with potential for improvement or long periods of remission
Permanent: Condition with no expectation of improvement.

I hereby certify that the above information is true. False verification may result in the disqualification of the applicant.

Full name (Print&Sign):__________________________ Telephone: _______________________