



**RTA Mobility Certifications Department
Americans with Disabilities Act Application**

ADA Application Part A

RTA Mobility ADA Application Part A, Part B and Medical release information must be submitted together. Incomplete applications will be returned to the applicant and/or agency. To ensure application is processed in a timely manner, all questions must be answered. All information is kept confidential.

ADA Application Part A to be completed by applicant or legal guardian.

New Application Re-certification

Last Name: _____ First: _____ MI: _____

Address: _____ Apt. / Unit #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-mail: _____

Preferred Method of Communication (if by phone, specify #): _____

Primary Language: _____ Date of Birth: _____

Applicant Signature: _____

Mailing Address (if different): _____

City: _____ State: _____ Zip Code: _____

Emergency Contact Information

Name: _____ Relationship: _____

Address: _____ Apt. / Unit #: _____

City: _____ State: _____ Zip Code: _____

ADA Application Part A

Home Phone: _____ Cell: _____

Work Phone: _____ Email: _____

Applicant completes each of the following questions:

1. Describe your disability and how it prevents or limits your use of RTA Transit services. _____

2. Is this condition temporary? Yes No

If temporary, what is the expected duration? _____

Do you need a (PCA) Personal Care Attendant? Yes No

4. How does the PCA assist you, such as getting to your destination or with activities after you arrive at your destination? _____

5. How do you travel now? Check all that apply.

Walk Drive Ride in car Taxi Use Fixed Route Public Transit

6. Have you used RTA Transit services? Yes No

If yes, where did you go?

Medical Appointments Library Senior Center
 Shopping Work Other: _____

7. Which of these aids do you currently use when traveling? Check all that apply.

Portable Oxygen Prosthetic leg Walker
 Manual Wheelchair Electric Wheelchair Leg Brace
 Rollator Service Animal Crutches
 Cane White Cane Power Scooter

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Note: Combined total weight includes weight of wheelchair and weight of rider. Manual and Power Scooters and Wheelchairs must be safe to transport and must be secured for transportation. Is your power scooter, wheelchair, or mobility device larger than 30" X 48" or over 600 pounds when occupied?

Yes No Not Applicable Unknown

8. Do you need assistance when you travel in the community?

Yes No Sometimes

What type of assistance do they provide for you? _____

9. Can you climb three steps (11 to 15 inches) with a handrail, without assistance from another person?

Yes No Sometimes

10. Does weather impact your ability to use the fixed route bus system?

Yes No Sometimes

Explain: _____

11. Describe the environmental barriers around your home or apartment that may prevent you from getting to the bus stop (steps, lack of sidewalks, damaged sidewalks, hills, gravel, distance, weather, lack of curb cuts, air quality, etc.).

12. Are you able to navigate to the nearest bus stop without assistance?

Yes No Sometimes

13. Can you cross streets with very little traffic where there are no traffic controls or stop signs without assistance?

Yes No Sometimes

14. Can you cross a busy intersection at traffic lights?

Yes No Sometimes

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15. Can you cross at busy intersections with multiple lanes?

Yes No Sometimes

16. Are you able to ask for and follow written and oral information?

Yes No Sometimes

17. Are you able to recognize your destination or landmark near your destination?

Yes No Sometimes

18. Are you able to tell time?

Yes No

19. Are you able to count money?

Yes No

20. Are you able to read a bus schedule?

Yes No

21. Are you able to read and understand a bus schedule with an assistive device?

Yes No

22. Have you requested or participated in Travel Training?

Yes No

I hereby certify, under the penalties of perjury, that the information given above is true and correct. I acknowledge that RTA Mobility ADA certification department will rely on the information provided in making a determination as to my eligibility for RTA Mobility ADA service. I agree that if any of the information provided is false or misleading, RTA Mobility ADA certification department has the right to revoke my application for RTA Mobility ADA service. To request this document in an alternative format or to request accommodations to complete application. RTA Mobility ADA Certification Department will take reasonable steps to provide accommodations to individuals who are unable to read, speak, write or understand English. Interpretation (oral) and translation (written) services are available to RTA Mobility riders with limited English proficiency (LEP).

Applicant's Signature: _____

Date: _____

**If you have any questions, call 1-800-270-9553 option 3, option 6 or (Maryland Relay: 711).
Return completed application to: RTA Mobility Certifications Department: 8510 Corridor
Rd. Suite 110, Savage, MD 20763 Fax: 443-285-0050 or Email:**

RTAMobilityservices@transitRTA.com

ADA Application Part A

Complimentary transportation to and from RTA Mobility ADA interview is available if needed. To request this document in an alternative format or to request accommodations to complete RTA Mobility ADA application process, call 1-800-270-9553, option 3, option 6 or email: RTAMobilityservices@transitRTA.com RTA Mobility will take reasonable steps to provide access to individuals who are unable to read, speak, write or understand English. Standardized procedures have been developed to ensure that interpretation (oral) and translation (written) services are available to RTA Mobility riders with Limited English Proficiency (LEP).

There are several types of public transportation options available throughout the State of Maryland depending on the county in which you reside. **RTA Transportation Services:** Regularly scheduled bus service at designated bus stops along specific routes on set schedules. All RTA Mobility service vehicles are equipped with wheelchair lifts for individuals with disabilities, including individuals in wheelchairs unable to use the steps. Regular RTA buses are equipped with ramps, kneeling buses that lower to the ground and voice announcements. **Travel Training:** Center for Mobility Equity offers free one-on-one or group training to teach people with disabilities how to ride RTA fixed and paratransit services. For more information call: 240-581-5800.

ADA Mobility Service: Curb to Curb or Door-to-Door shared ride public transportation service for people whose disability prevents them from using RTA Transportation services. If your disability or environmental barriers prevent you from using RTA Transportation services, you may be eligible for full or partial RTA Mobility ADA service. Your ability to ride RTA Transportation services will be evaluated thru the use of this application and an in person interview that may include a functional assessment. A determination will be made within twenty one (21) business days of your in person interview or presumptive eligibility will be granted. When you are contacted for the interview, it is to your benefit to schedule the interview as soon as possible. Your application will not be processed without a face to face interview.

What is the Americans with Disabilities Act – ADA? The Americans with Disabilities Act (ADA) is a civil rights law. The intent of the ADA is to remove barriers that have prevented people with disabilities from fully participating in life. Under the ADA, RTA Transportation service is to be the primary means of public transportation for everyone, including people with disabilities.

IMPORTANT: Medical condition or eligibility for other disability programs do not necessarily qualify you to use RTA ADA Mobility service (Curb to Curb or Door-to-Door). Not having access to RTA Transportation services is not a qualifier under ADA.

RTA Mobility assures full compliance with Title VI of the Civil Rights Act of 1964 and related statutes and regulations in all programs and activities. Title VI of the Civil Rights Act requires that no rider/person in the United States shall, on the grounds of race, color, national origin, sex, age and disability be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination under any program or activity of the RTA Mobility Services.



ADA Medical Information Release

Authorization to Contact Healthcare Professional(s) Application must be signed to be considered complete

I understand that the information on this application will be kept confidential and shared only with professionals involved in evaluating my eligibility. I certify that to the best of my knowledge, the information on this application is true and correct. I understand that providing false or misleading information could result in my eligibility status being terminated.

Applicant Printed Name: _____ Date: _____

Applicant Signature: _____

Home Phone: _____ Cell Phone: _____

If this medical release form is completed by someone other than applicant

Name: _____

Relationship to Applicant: _____

Signature: _____

Home/ Office Phone: _____ Cell: _____ Fax: _____

Name of Healthcare Professional: _____

Office Address: _____

City: _____ State: _____ Zip Code: _____

I certify that the information provided in this application is true and correct based upon the information given to me by the applicant or by my own knowledge of the applicant's health condition, disability or I have legal authority to complete this application.

ADA Medical Information Release

I am granting permission to RTA Mobility ADA Certification Department to contact the professional who has filled out this application or given supplemental verification of my condition. I authorize the following professional(s) to release medical information to RTA Mobility ADA Certifications Department about my disability and its effect on my ability to travel on the fixed route transit system. I understand that the information released will be used safely to determine this eligibility and that I may revoke this authorization at any time. Unless earlier revoked, this form will permit the person listed to release the information until 60 days after the date appeared below. Healthcare Professionals include the following:

Name of: Doctor or Clinic:

Professional Title: _____

Professional Specialization: _____ License Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Office Phone: _____ Cell: _____ Fax: _____

- | | |
|--|--|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Physician's Assistant |
| <input type="checkbox"/> Certified Nurse Practitioner | <input type="checkbox"/> Licensed Clinical Psychologist |
| <input type="checkbox"/> Podiatrist (foot and ankle disability) | <input type="checkbox"/> Registered Nurse |
| <input type="checkbox"/> Psychiatrist (psychiatric disabilities) | <input type="checkbox"/> Optometrist (visual disabilities) |

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ADA Application Part B

In order to complete this application on behalf of the applicant you must be a certified or licensed professional. The applicant is asking you to review the information on this application and to complete and sign Part B of this form certifying that the applicant has a disability that prevents them from using RTA fixed route transit service. This information will be used to determine if the applicant qualifies for RTA Mobility ADA service (Curb-to-Curb/Door-to-Door) or is able to use RTA fixed route transit service for some or all travel. Under the Americans with Disabilities Act (ADA) if a person has the functional and cognitive ability to use RTA fixed route transit service, the applicant is not eligible for RTA Mobility services. Disability alone, distance to and from the bus stop, or availability of RTA fixed route transit service is not by itself a qualifier for RTA Mobility services.

If you have any questions completing Part B, call 1-800-270-9553, opt. 3, opt. 6. Please include all applicable information in order to not delay the applicant's application. A Licensed/Certified Healthcare Professional with knowledge of the applicant's functional ability, must complete this form.

Required Licensed/Certified Healthcare Professional Information.

Name of: Doctor or Clinic: _____

Patient Name: _____

Professional Title: _____

Professional Specialization: _____ License Number: _____

Clinic or Agency: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Office Phone: _____ Office Fax: _____

Signature or Office Stamp of Healthcare Professional:

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Doctor or Clinic.

Applicant has been a patient since: _____ Last evaluation: _____

Applicant's disability (required): _____

Indicate the applicant's condition or disability. Check all that apply:

Currently receiving dialysis? Yes No How often? _____

Undergoing cancer treatment? Yes No Expected duration? _____

Arthritis? Yes No Type? _____

Amputation Yes No Extremity? Prosthetic?

Neurological Cognitive Condition

Mild Moderate Severe Profound

Pulmonary Disease? Yes No
 Oxygen Tank Size? _____

Hearing Impairment? Yes No
 Degree of Hearing Loss? _____

- | | |
|--|--|
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Legally Blind |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Cardiac Disease | <input type="checkbox"/> Neuromuscular Condition |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Severally Visually Impaired |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Traumatic Brain Injury |

Seizure Disorder

Does the applicant experience seizures? Yes No

Type? _____ How Often? _____ Recovery Time? _____

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Are seizures preceded by an aura? Yes No

Is applicant taking seizure medication? Yes No

Are seizures currently controlled? Yes No

Date of applicant's last seizure? _____

Is applicant able to function safely in the community? Yes No

Is the condition temporary? Yes No

What is expected duration? _____

Cognitive Disorder

Does the applicant have a Cognitive Disorder Yes No

If no, proceed to Behavior Health section.

What is the diagnosis of the applicant's condition? _____

Does the applicant's condition affect behavior? Yes No

If yes, describe: _____

Is the applicant able to travel alone? Yes No

Does the applicant have the ability to travel alone? Yes No

If yes, check one:

One Step Direction Two Step Direction Three Step Direction

Would the applicant know what to do if they became lost out in the community?

Yes No

Would the applicant be able to recognize and avoid dangers they might encounter when travelling in the community?

Yes No

Does the applicant have the ability to safely cross streets? Yes No

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If no, check all that apply to safely cross streets. Provide additional information:

- Attention Processing
 Foresight/Planning Short Term Memory
 Problem Solving Safety Awareness and Judgment
 Other: _____
-

Behavioral Health

Does the applicant have a Behavioral Disorder? Yes No

If no, proceed to Visual Disability section.

What is diagnosis of the applicant's condition? _____

What is the prognosis for this condition for independent function? _____

Is the applicant taking medication for their condition? Yes No

If yes, does the medication allow the applicant to function in the community?

Yes No

Has the applicant recently had a decline in function due to an adjustment in medication?

Yes No

Does the applicant experience hallucinations? Yes No

If yes, explain how the hallucinations impair the applicant's ability to function in the community: _____

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Does the applicant experience anxiety or panic attacks in closed places, crowded places, or unfamiliar places?

Yes No

If yes, explain: _____

Visual Disability

Does the applicant have a Visual Disability?

Yes No

If no, proceed to Conclusion section.

What is the diagnosis of the applicant's condition? _____

What is the prognosis? Is the condition stable, degenerative or otherwise changing?

If the applicant is partially sighted, are they able to see steps and curbs?

Yes No

Is vision affected by different lighting conditions?

Yes No

If yes, check all that apply:

Bright sunlight Dimly lit or shaded places Nighttime

Applicant will benefit from large print schedules other: _____

Mobility Disability

Is the applicant's ability to travel outside alone affected by other conditions such as environmental noise, inability to distinguish traffic flow patterns, sensitivity to light or temperature extremes, etc.?

If speech or communication is present: _____

ADA Application Part B

How far can the applicant operate a wheelchair or ambulate with or without a mobility aid and without lengthy rest breaks?

No independent mobility Greater than ½ mile

Applicant can walk _____ city blocks

How long can applicant wait at a bus stop with a bench and shelter? _____

How long can applicant wait at a bus stop without a bench and shelter? _____

Provide other information that will help RTA Mobility a make eligibility determination: _____

Could the applicant train to independently travel and use RTA fixed route transit services?

Yes No

If no, explain: _____

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