

# OSU-STILLWATER COMMUNITY TRANSIT SYSTEM



## PARATRANSIT ELIGIBILITY APPLICATION



Revised January 2023

**The Bus**, Stillwater's public transportation system, provides fixed route service to all of the citizens of Stillwater. **Every bus** is equipped with a lift or ramp for those passengers that can not negotiate the steps on the buses. **The Bus** also offers a Paratransit service, which provides door-to-door service (as modified by FTA guidance for origin to destination for individuals who cannot use fixed-route service to make their trips). The Paratransit service area complements the fixed route system and utilized guidelines established to be eligible for this service, functional limitations of an individual's disability must prevent use of a regular fixed-route service. Age, distance to a bus stop or inability to drive, by themselves, are not taken into consideration in determining eligibility. While your doctor's verification of need is required for application, the final determination of eligibility will be made by the Paratransit ADA Certification.

**Eligibility for use of Paratransit Services is determined by review of application and verification provided by Health Care Specialist.**

**Use of the OSU-Stillwater Community Paratransit service is based on the service area, which can be found online at <http://www.parking.okstate.edu/>**

Applicants for Paratransit service should complete Section I, Parts A through C. They should then provide their physician with Part D, to be completed by them and returned to applicant.

If you are able to use the fixed route bus system, but wish to apply for a disability card to receive reduced fares and priority seating, please complete the Disability card eligibility application in Part E.

Parts A through D, **along with a photocopy of a picture ID**, should be returned to:

OSU Student Disability Services Office  
ADA Certification  
Oklahoma State University  
1514 West Hall of Fame Ave #103A  
Stillwater, OK 74078  
(405) 744-7116 (v/t)  
Fax: (405) 744-1143

***The application must be filled out completely or it will not be processed!***

**Section I, Part A Contact Information**  
**To be completed by, or for, the applicant**

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_  
(Street)

\_\_\_\_\_ **Home Phone:** (\_\_\_\_) \_\_\_\_\_  
(City) (Zip)

**Business Address:** \_\_\_\_\_

\_\_\_\_\_ **Business Phone:** (\_\_\_\_) \_\_\_\_\_  
(City) (Zip)

**Date of Birth:** \_\_\_\_\_ **Sex:**  Male  Female  
(mm/dd/yyyy)

**Emergency Contact** \_\_\_\_\_ **Phone Number** \_\_\_\_\_

**Do you use a Primary Care Attendant (PCA) ?** Yes  No

**Communication method:**  Speak independently  Communication Device  Sign Language  Writing  Other \_\_\_\_\_

**Aids:**  None  Wheelchair  Crutches  Walker  Power wheelchair  Scooter  White Cane  Service animal  Oxygen tank  Other \_\_\_\_\_

**Type of service expected to use:**  Fixed route (regular service)  Paratransit

**Does your disability require you to have assistance from the door of the bus to the door of your origin or destination?**  Yes  No

**Please provide names of others that can schedule trips on your behalf:**

\_\_\_\_\_

**Are you currently OSU Faculty/Staff/Student?**  Yes  No

To be eligible provide the following for verification:

CWID: \_\_\_\_\_

16 Digit number from your Valid OSU ID \_\_\_\_\_

(Copy PART A to Transit Office)

**Section I, Part B Self Evaluation**  
**To be completed by, or for, the applicant**

Please answer the following questions. If you need help filling out the application, please call (405) 744-7116 (v/t) Monday thru Friday from 9:00 am until 5:00 pm for assistance. Your answers to these questions in this section will help us better understand your functional ability in specific areas.

**1. Physician's Name:** \_\_\_\_\_

**Physician's Address:** \_\_\_\_\_  
(Street)

\_\_\_\_\_ **Physician's Phone:** ( ) \_\_\_\_\_  
(City) (Zip)

**2. Physician's Name (if applicable):** \_\_\_\_\_

**Physician's Address:** \_\_\_\_\_  
(Street)

\_\_\_\_\_ **Physician's Phone:** ( ) \_\_\_\_\_  
(City) (Zip)

**Disability description:** \_\_\_\_\_

\_\_\_\_\_

**1. Please describe how your disability prevents you from using the regular OSU-Stillwater fixed route bus system:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Is your disability temporary  Yes  No
3. Do you currently use OSU-Stillwater fixed route bus service?  Yes  No
4. Have you had your disability for more than one year?  Yes  No
5. How far can you walk without assistance? (If you use a wheelchair or other mobility device, how far can you travel using that device?) \_\_\_\_\_
6. Does your disability change from day to day in a way that prevents you from using the regular buses?
- YES, my condition is good on some days and bad on other days.
- NO, my condition doesn't change much from one day to another.

**If you answered YES on question 6, answer the next two questions, otherwise, skip to question 7.**

A. On a day when my condition is GOOD, (choose ONE):

- a.  I can't travel outside my house
- b.  I can get to the curb in front of my house
- c.  I can travel 1 block
- d.  I can travel 2 blocks
- e.  I can travel 4 blocks (1/4 mile)
- f.  I can travel 6 blocks (1/2 mile)

B. On a day when my condition is BAD, (choose ONE):

- a.  I can't travel outside my house
- b.  I can get to the curb in front of my house
- c.  I can travel 1 block
- d.  I can travel 2 blocks
- e.  I can travel 4 blocks (1/4 mile)
- f.  I can travel 6 blocks (1/2 mile)

7. Does the weather ever keep you from using fixed route bus service?

Yes (describe what kind and how this keeps you from using fixed route bus service) : \_\_\_\_\_

\_\_\_\_\_

No

8. If you use a manual wheelchair, please list your weight & the weight of the chair. Your weight \_\_\_\_\_ Wheelchair weight \_\_\_\_\_

9. If you use a Personal Care Assistant (PCA), check all that apply.

The PCA helps me:

- get to the bus stop
- get on and off the bus
- while I ride the bus
- get where I am going once I am off the bus
- other : \_\_\_\_\_

10. Which of the following limits your ability to use the fixed route buses?  
(check all that apply)

- physical disability
- visual impairment/blindness
- cognitive disability

Please describe why this limits your ability to use the fixed route buses:

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11. How are your transportation needs being met now? Please check all that apply.

- walking
- personal transportation (car)
- public transportation (bus, taxi)
- agency-sponsored rides (who?) \_\_\_\_\_
- Paratransit service (who?) \_\_\_\_\_
- ambulance (who?) \_\_\_\_\_
- friend/ relative
- other \_\_\_\_\_

**12. Most of the time can you:**

Cross the street, if there are curb cuts?

Always  Sometimes  Never  Not sure

Cross a 2 lane street?

Always  Sometimes  Never  Not sure

Cross a 4 lane highway with stop lights?

Always  Sometimes  Never  Not sure

Go up and down hilly terrain

Always  Sometimes  Never  Not sure

Tolerate temperature extremes (hot/cold)

Always  Sometimes  Never  Not sure

Locate signs at night

Always  Sometimes  Never  Not sure

**13. Are you able to perform the following functions without assistance?**

Find your way between familiar locations  Yes  No

Signal a bus driver to get off at familiar stop  Yes  No

Grasp coins, passes and handles  Yes  No

Communicate addresses, destinations, and telephone numbers  Yes  No

Ask for, understand, and follow directions  Yes  No

Deal with unexpected situations or changes in routine  Yes  No

Recognize a destination or landmark  Yes  No

**14. Can you wait 10 to 15 minutes at a bus stop?**

Yes, always

Yes, sometimes

No, I can only wait \_\_\_\_\_ minutes

I don't know

**15. Have you ever had training using a fixed route bus service?**

Yes  No

If yes, who trained you? \_\_\_\_\_

**16. List three locations where you would like to have training on using the fixed route bus:**

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**17. Please list your most frequent trips and how you get there now**

a. Origin : \_\_\_\_\_ Round trip? \_\_\_\_\_  
Destination? \_\_\_\_\_ How often? \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
(City) (Zip)

by OSU-Stillwater Transit bus  Other \_\_\_\_\_

b. Origin : \_\_\_\_\_ Round trip? \_\_\_\_\_  
Destination? \_\_\_\_\_ How often? \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
(City) (Zip)

by OSU-Stillwater Transit bus  Other \_\_\_\_\_



**Section I, Part C Applicant Certification**  
**To be completed by, or for, the applicant**

I understand that the purpose of this application is to determine if I am eligible for ADA Paratransit services. OSU-Stillwater Community Transit or its contracted agents may need to talk to me or to see me at another time for an in-person interview and/or functional assessment to complete the application process. I understand that I must be truthful in answering the questions in this form and at my in-person assessment, if required. Giving false information is against the law and may result in loss of Paratransit service and/or criminal penalties. I agree to notify OSU-Stillwater Community Transit if I am no longer eligible for Paratransit service.

I authorize my physician, health care provider, trainer, specialist to discuss my diagnosis, treatment plan, medications, and/or prognosis for the purpose of determining my ability to use accessible OSU-Stillwater Community Transit buses.

I certify that the information in this application is true to the best of my knowledge. I understand if OSU-Stillwater Community Transit or its authorized agents receive information regarding change in my functional mobility, my eligibility status may be reviewed and changed. I understand that OSU-Stillwater Community Transit or one of its contracted agents will notify me of any change in my eligibility status and I may appeal such decision within sixty (60) days of notification.

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\_\_\_\_\_  
(Applicant's Name, printed)

\_\_\_\_\_  
(Applicant's signature)

\_\_\_\_\_  
(Date)

**Copy of Applicant ID Card included**

**To be filled out if the applicant was helped by another person in completion of this application:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(Zip)

Relationship with applicant: \_\_\_\_\_

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize \_\_\_\_\_, my personal care attendant, to  
(name of PCA)

release and obtain information regarding my application/services for Paratransit.

Your records are protected under a number of federal and state confidentiality regulations and cannot be disclosed without your written consent unless otherwise provided for in state and federal regulations. You may revoke this consent in written request at any time except to the extent that action has been taken in reliance on it (e.g., information has been sent or received prior to your revocation, etc.)

You do not authorize further release to any other party. You further understand that Paratransit/OSU-Stillwater Community Transit System and its staff, employees, coordinators, and directors cannot be responsible for confidentiality of information disclosed after said information has been released pursuant to this authorization, and you hereby release Paratransit/OSU-Stillwater Community Transit System from any liability arising from such disclosure.

\_\_\_\_\_  
Printed/Typed Name

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**The following Section (Part D) is to be filled out by a Health Care Professional. Failure to have this section completely filled out by the Health Care Professional will result in delay in processing of application.**

**Section I, Part D Professional Verification**  
**to be filled out by Health Care Professional**

Dear Health Care Professional:

You are being asked by \_\_\_\_\_ to provide information  
(applicant)

regarding their ability to use our transit system. Federal law requires that OSU-Stillwater Community Transit provide Paratransit services to persons who cannot use fixed-route transit services. The information you provide will allow us to evaluate this request and its application to specific trip requests. Certification to use this service will not be based solely on your verification in this document. Thank you for your cooperation in this matter.

To qualify for Paratransit services, a person must be unable to use regular public transit due to physical or cognitive disability. Individuals qualify if:

1. as the result of their disability, they cannot board, ride, or disembark a OSU-Stillwater Community Transit fixed route bus (all fixed route buses are lift-equipped);  
or
2. they have a specific impairment-related condition which prevents them from getting to/ from a bus stop.

PLEASE NOTE: This does not include persons who find it uncomfortable, inconvenient, or difficult to get to and from bus stops.

Resources for this program are limited and your evaluation of each person must be based solely upon the individual's ability to use regular transit. Your verification should consider only presence of a disabling condition, not the applicant's age or economic status. Please exercise care in evaluating applicants for this program. Evaluation is based on federal guidelines are used for establishing paratransit accessibility. The determination will be applicable for use on any of the nation's ADA compliant paratransit services.

**CERTIFICATION PROCESS**

1. Applicant has completed Parts A through C.
2. Health Care Professional completing Part D must be guided by criteria explained herein.
3. OSU-Stillwater Community Transit or its authorized agents may contact the certifying health care professional to verify accuracy of the information.
4. OSU-Stillwater Community Transit's certification agent, the OSU Student Disability Services Office, will make the final determination of the applicant's eligibility.
5. The application must be filled out COMPLETELY for processing to occur.

OSU-Stillwater Community Transit is a limited special transportation service for disabled persons who, because of cognitive or physical disability, find it IMPOSSIBLE to use regular public transportation. All parts must be completely filled out by the authorized person who signs below. Incomplete forms will be returned to the applicant.

**A. Indicate nature of applicant's disability** (check as many as may apply):

- Non-ambulatory (uses wheelchair for mobility)
- Impaired or assisted ambulatory requiring special mobility aid \_\_\_\_\_
- Arthritis/Osteoarthritis (specify extremity) \_\_\_\_\_
- Amputation (specify extremity) \_\_\_\_\_
- Cerebrovascular Accident
- Pulmonary Ills (does applicant require portable Oxygen Yes  No
- Neurological Impairment
- Cardiac Ills
- Kidney disease/dialysis
- Sight disability Legally blind  Visually impaired
- Incoordination
- Mental Retardation Moderate  Severe  Profound
- Cerebral Palsy
- Autism
- Severe Muscle Spasms
- Seizures
- Loss of consciousness
- Mental illness (specify what it is about cognitive disability that limits use of regular bus service)

\_\_\_\_\_  
\_\_\_\_\_

- Other \_\_\_\_\_  
\_\_\_\_\_

**Describe type and severity of disability in detail and how it prevents use of transit:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**B. The disability is:** Permanent  Temporary

If temporary, expected duration is \_\_\_\_\_

**In your opinion, must this individual bring a competent attendant on each trip?**  
Yes  No

**If applicant is visually impaired or blind, developmentally disabled, suffers from neurological impairment or is mentally limited, has applicant ability to receive training in fixed route buses?** Yes  No

**How far can the applicant walk unassisted? (If applicant uses a wheelchair or other mobility device, how far can the applicant travel using that device?):**

- 1 block
- 2 blocks
- 4 blocks (1/4 mi)
- No limitation
- \* Other \_\_\_\_\_

**Is there any other effect of the disability of which OSU-Stillwater Community Transit should be aware? Please provide an explanation.** \_\_\_\_\_

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**C. Is the applicant on any medication which might have an impact on ability to use public transportation**  Yes  No Explain \_\_\_\_\_

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**D. Your professional area of specialization is:**

- Family Physician
- Cardiologist
- Podiatrist
- Optometrist
- Audiologist
- Psychologist
- Physical Therapist
- Rehabilitation Specialist
- Independent Living Specialist
- Registered Nurse/LPN
- Other \_\_\_\_\_

**HEALTH CARE PROFESSIONAL CONTACT INFORMATION**

**Name:** \_\_\_\_\_

**Title:** \_\_\_\_\_ **Agency/Company Name:** \_\_\_\_\_

**Professional License # (if applicable):** \_\_\_\_\_

**Office Address:** \_\_\_\_\_

(Street)

\_\_\_\_\_ **Office Phone Number:** (\_\_\_\_) \_\_\_\_\_

(City)

(Zip)

I hereby certify that the above information is true. The OSU Student Disability Services office will make the final determination on the applicant's eligibility for OSU-Stillwater Community Paratransit service.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

**THANK YOU FOR YOUR ASSISTANCE IN PROCESSING THIS APPLICATION!**



**Section II, Disability Certification Card Application**  
**(Fixed Route Only)**

**Contact Information**

**To be completed by, or for, the applicant**

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_  
(Street)

\_\_\_\_\_ **Home Phone:** ( ) \_\_\_\_\_  
(City) (Zip)

**Business Address:** \_\_\_\_\_

\_\_\_\_\_ **Business Phone:** ( ) \_\_\_\_\_  
(City) (Zip)

**Date of Birth:** \_\_\_\_\_ **Sex:**  Male  Female  
(mm/dd/yyyy)

**Do you use a Primary Care Attendant (PCA) ?** Yes  No

**Physician/Evaluator's Name:** \_\_\_\_\_

**Physician/Evaluator's Address:** \_\_\_\_\_  
(Street)

\_\_\_\_\_ **Physician/Evaluator's Phone:** ( ) \_\_\_\_\_  
(City) (Zip)



**Disability description:** \_\_\_\_\_  
\_\_\_\_\_

**Communication method:**  Speak independently  Communication Device  Sign Language  Writing  Other \_\_\_\_\_

**Aids:**  None  Wheelchair  Crutches  Walker  Power wheelchair  Scooter  Cane  Service animal  Oxygen tank  Other \_\_\_\_\_

**Are you currently OSU Faculty/Staff/Student?**

Yes  No

If yes please provide the following:

CWID: \_\_\_\_\_ ; 16 Digit Number from OSU ID \_\_\_\_\_  
Used to verify Valid ID, must be updated if ID is replaced

Please attach documentation of your disability from a qualified professional. Acceptable forms of documentation include:

- Documentation from a physician regarding a medical or developmental disability.
- Report from a psychologist/diagnostician/psychiatrist regarding mental illness or learning disability.
- Audiologist report regarding deafness or hearing impairment.
- Ophthalmologist report regarding visual impairment.

**Mail completed application to:**

**OSU Student Accessibility Services  
ADA Certification  
Oklahoma State University  
1514 West Hall of Fame Ave #103A  
Stillwater, OK 74078  
Stillwater, OK 74078  
Fax: (405) 744-1143**