TEL·A·RIDE
Application for ADA Paratransit Eligibility

ACCESSIBLE SERVICES AND THE AMERICANS WITH DISABILITIES ACT

Individuals who cannot board, ride or get off a regular public transit bus because of a disability may be eligible under the Americans with Disabilities Act (the ADA) for paratransit services. Charleston Area Regional Transit Authority (CARTA) provides TEL·A·RIDE, curb-to-curb, shared-ride accessible paratransit throughout its service area.

Riders must meet the vehicle at the curb. TEL·A·RIDE drivers cannot assist passengers from their residence to the vehicle or from the vehicle to their destination point. Please remember these restrictions when completing this application.

If the effects of your disability or medical condition prevent you from riding CARTA buses, you may be eligible for TEL·A·RIDE some or all of the time. If your disability just makes riding the bus more difficult or inconvenient, you may not be eligible for TEL·A·RIDE under the Americans with Disabilities Act (ADA).

If you believe that you may be eligible, please complete the enclosed Application for ADA Paratransit Eligibility and return it to the address given on Page 11.

Part I of this application is to be completed by the applicant. Part II of this application is to be completed by a health care professional familiar with your disability. It is important that you provide complete information about the effects of your disability in the application.

You will be notified in writing on whether or not you are eligible for TEL·A·RIDE services within 21 days of receiving your completed application.

If you are not eligible, appeals information will be sent to you. Appeals will be accepted within 60 days of the initial eligibility decision.
Part I

For the Applicant to Complete

Please Print

A. Personal / Contact Information

Name (first, middle, last):

__________________________________________________________________________  E-Mail: _______________________

Home Address: ___________________________________________________________  Apt. #: __________

City:  ___________________________________________________________  Zip: __________

Mailing Address (if different from home):

__________________________________________________________________________  Apt. #: __________

City: ___________________________________________________________  Zip: __________

Daytime Phone: ( )  TDD/TTY: ( )

Evening Phone: ( )  Cell Phone: ( )

Birth Date:  ____ / ____ / ______  □ Female    □ Male

If you need any future written information provided to you in an accessible format, please check which format you prefer:

□ Diskette/CDR  □ Audio Tape  □ Braille  □ Large Print

□ Other ___________________________________________

In case of emergency, whom should we contact?

Name: _____________________________________________________________

Relationship: _______________________________________________________

Day Phone: ( )  Evening Phone: ( )
Part I
For the Applicant to Complete

B. Disability Information

1. What is the disability which prevents you from using our fixed route service?

________________________________________________________________________

Is this condition temporary? □ Yes □ No
If yes, please indicate the expected recovery date: / / 

2. Please briefly describe how your disability prevents you from using the fixed route system.

________________________________________________________________________

3. Which of the following mobility aids (if any) do you use? (Please check all that apply)

Manual Wheelchair Support Cane
Electric Wheelchair White Cane
Powered Scooter Crutches
Service Animal Walker
Portable Oxygen Other

Do you require the assistance of a Personal Care Attendant when you travel using transit?

_____ Yes _____ No _____ Sometimes (Please explain)

________________________________________________________________________

If yes, does the personal care attendant riding with you on the vehicle help you in: (Please check all that apply)

_____ Getting on and off the bus
_____ Helping me when I get where I am going
_____ Interpret for me
_____ Other bus-related assistance (please explain)

________________________________________________________________________

Name of Attendant: ____________________________
Part I
For the Applicant to Complete

C. Mobility Information

1. With the use of a mobility aid, or on your own, are you able to travel from your residence to the curb?
   Yes  No  Sometimes (please explain)

2. Does the weather affect your ability to travel outside and use the bus service?
   _____ Yes  _____ No

3. With the use of a mobility aid, or on your own, how far are you able to travel without the assistance of another person?
   _____ Less than 200 feet  _____ ½ mile (6 blocks)
   _____ ¼ mile (3 blocks)  _____ ¾ mile (9 blocks)
   _____ 1 mile or more

4. Are you able to climb three 12-inch steps without assistance?
   _____ Yes  _____ No

5. Are you able to wait outside without support for up to fifteen minutes?
   _____ Yes  _____ No

6. Are you able to give addresses and telephone numbers upon request?
   _____ Yes  _____ No

7. Are you able to recognize a destination or landmark?
   Yes  No (please explain)
Part I
For the Applicant to Complete

8. Are you able to ask for, understand, and follow directions?
   Yes           No           (please explain)

9. Are you able to deal with unexpected situations or changes in routine?
   Yes           No           (please explain)

10. Are you able to independently travel through crowded and/or complex facilities??
    Yes           No           (please explain)

11. How many steps are there at the entrance you use at your residence?
    
12. Can you get to and board the TEL*A*RIDE vehicle without the help of another person?
    Yes           No           (please explain)

13. How would you describe the terrain where you live? (Example: steep hill, flat, long gradual hill, etc.)

14. Are there sidewalks in your neighborhood?
    _____ Yes     _____ No
D. Travel Information

1. When are you unable to use Fixed Route bus? (Please check any of the following that apply to you):

☐ I can use a regular fixed-route bus service for some trips, but other times there are barriers that prevent me from using the bus.

☐ I have difficulty understanding and/or remembering all of the things I would have to do to find my way to and from the bus and ride the bus.

☐ I have difficulty getting to and from bus stops because I become disoriented easily.

☐ I have a visual disability and I have difficulty finding my way to and from the bus stop.

☐ I can only get to and from bus stops if the distance is not too great and there are curb cuts and sidewalks on the route.

☐ I can only wait at bus stops if there is a bench and shelter.

☐ I have difficulty or cannot climb stairs and can only board a bus if there is a lift or ramp.

☐ I have a health condition and cannot ride the bus if there walk is too far or if the weather is too hot.

☐ I have difficulty getting to and from bus stops because of busy streets and intersections.

☐ The severity of my disability can change from day to day.

☐ I can ride the bus only when I am feeling well.

☐ I can never use the fixed-route bus service by myself.
   Please explain ________________________________

☐ I am not able to use the bus for the other reasons.
   Please explain ________________________________
Part I
For the Applicant to Complete

2. Have you ever used the Fixed-Route bus service?
   □ Yes, I typically use the fixed-route service _____ times a week.
   □ Yes, I used to but stopped because ______________________________.
   □ No, I have never used the fixed-route service.

3. Is there something that might help you to ride the fixed-route buses?
   □ Yes, route and schedule information.
   □ Yes, being able to get buses with ramps/lifts.
   □ Yes, if the bus stops were closer to where I live.
   □ Yes, if the bus stops were closer to the places I need to go.
   □ Yes, learning to use the buses.
   □ Yes, a communication aide.
   □ Yes, other (describe) ________________________________

   □ No, none of these would help.

4. What is the closest bus stop to your home? Please give the location
   (example: corner of Main Street and Nova Road).
   ____________________________________________________________________

5. If The CARTA offered free instruction to anyone interested in learning how to
   ride the fixed-route buses, would you be interested in this type of training.
   _____ Yes       _____ No (please explain) ________________________________
   ____________________________________________________________________
Part I
For the Applicant to Complete

E. Applicant Certification

I certify that the information in this application is true and correct. I understand that knowingly falsifying the information will result in denial of service. I understand all information will be kept confidential, and only information required to provide the services I request will be disclosed to those who perform the services.

Sign Here:
Applicant’s signature ___________________ Date ______

If this application has been completed by someone other than the person requesting certification, that person must complete the following:

Name ________________________________
Mailing Address __________________________
City __________________ State ____ Zip Code ______
Daytime Phone __________________________
Signed _______________________________ Date ___ / ___ / ___

Please Note: It is your responsibility to notify us if you disability improves enough to change your eligibility status. If your condition improves after you have been determined eligible or we discover you submitted false information, your eligibility could be suspended or you may be asked to reapply.

Have you answered all of the questions and provided explanations where required?

INCOMPLETE APPLICATIONS WILL BE RETURNED.
Part II

For the Health Care Professional to Complete

Part II must be personally completed by an accepted, licensed health care professional.

A. Applicant Authorization – to be completed by applicant

I authorize the professional(s), listed below, to provide any information required to complete this certification. The information released will be used solely to determine my eligibility and I realize that I have a right to receive a copy of this information. I understand that I may revoke this authorization at any time.

Applicant’s signature ____________________________ Date ___ / ___ / ___
Name (health care professional) ________________________________
Agency name (if applicable) ________________________________
Mailing Address ____________________________________________
City __________________ State _____ Zip Code ___________
Telephone Number _________________________________________

Overview: As a health care professional familiar with the applicant, you are being asked by the applicant to provide information regarding his/her ability to use CARTA’s fixed-route transit services. CARTA may provide paratransit services (TEL*A*RIDE) to persons who cannot use the accessible fixed-route services. The information you provide will allow us to evaluate the request and to provide appropriate transportation services for the applicant. All information will be kept confidential.

To qualify for paratransit service: The applicant must be unable to use the accessible fixed-route bus services due to the effects of a disability.

Your certification should consider only the effects of disabling conditions.
Part II
Request for Professional Certification

Name of Applicant

1. Primary condition causing disability (please describe):
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   Severity   ____ Mild   ____ Moderate   ____ Severe   ____ Profound

2. Secondary condition causing disability (please describe):
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   Severity   ____ Mild   ____ Moderate   ____ Severe   ____ Profound

3. Expected duration of disability:
   _____ Temporary: Expected duration until _____________________________
   _____ Long Term: Conditions with potential for improvement or long periods of remission.
   _____ Permanent: Conditions with no expectations of improvement.

4. Capacity in which you know the applicant: ____________________________

5. Complete if the applicant has a visual impairment.
   Visual Acuity with Best Correction
   Right Eye _______   Left Eye _______   Both Eyes _______

   Visual Fields
   Right Eye _______   Left Eye _______   Both Eyes _______
Part II
Request for Professional Certification

6. If the applicant has a cognitive disability is the applicant able to:
   Give addresses / telephone numbers upon request? Yes No
   Recognize a destination or landmark? Yes No
   Ask for, understand and follow directions? Yes No
   Safely and effectively travel through crowded facilities? Yes No

7. If the applicant has a disability affecting mobility is the applicant able to:
   Wait outside without support for 10 minutes? Yes No Sometimes

8. Is the applicant’s ability to independently travel the distance affected by
   (check all that apply):
   _____ Hot weather
   _____ Cold weather
   _____ Steep hills
   _____ Street crossings
   _____ Other ________________________________
   _____ None of these

I hereby certify that the information in this section (Part II) is complete and accurate and was
completed by the undersigned.

_________________________________________  ________________________
Signed                                                                 Date

_________________________________________  ________________________
Print Name                                                                 Street Address

_________________________________________  ________________________
City                                                                                  State                   Zip

_________________________________________  ________________________
Telephone Number                                                                   License / Certification Number

Completion of this application by any other profession will not be accepted without prior authorization.
Profession (check one)

_____ Physician                                                                 _____ Physical Therapist
_____ Psychiatrist                                                                _____ Social Worker
_____ Psychologist                                                               _____ Rehabilitation Specialist
_____ Occupational Therapist                                                     _____ Physiatrist
Check List for Completion of Application

Please Return Completed Application (Parts I and II) to:

TEL*A*RIDE
ADA Coordinator
3664 Leeds Avenue
North Charleston, SC 20405

If you have any questions about the completion of this application please call the ADA Coordinator at 843-745-4101

Applicant must complete:
- All Information, Part I, Pages 1-7
- Applicant Signature, Part I, Page 7E
- Signature of person completing application (if other than applicant), Part I, Page 7E
- Applicant authorization signature, Part II, Page 8A

Health Care Professional must complete:
- All information, Part II, Pages 9-10
- Professional signature, Part II, Page 10