Dear Paratransit Applicant:

Enclosed is an application for the CARTA Tel-A-Ride accessible transit paratransit system. Tel-A-Ride is for individuals whose mobility impairment prevents them from using fixed-schedule bus routes. The application is intended to assess your abilities to determine if you are medically eligible to use Tel-A-Ride complementary service.

All sections of the application must be completed to process the application. Part II of the application must be completed by a Health Care Professional. This is necessary to determine your eligibility, as well as determining when and under what conditions you may require paratransit service. Paratransit eligibility may be determined on a trip-by-trip basis. All information will be kept confidential.

When you have completed and signed the application, mail it to:

TEL-A-RIDE
ADA Coordinator
5790 Casper Padgett Way
North Charleston, SC 29406

You will be notified as to your eligibility to use the service by mail within three weeks.

Please note that the Tel-A-Ride service area is a ¾ mile corridor on either side of the local fixed-route bus lines. Your origin and destination must be located within this service area. If you are requesting a pick-up at your home, it must be within the ¾ mile corridor. The ADA Coordinator will be happy to help you determine if your home is within the service area.

If you have any questions, or need assistance filling out the application, please contact the ADA Coordinator at (843) 529-0400 (voice), or if hearing impaired phone 711 (TTY).
TEL•A•RIDE
Application for ADA
Paratransit Eligibility

ACCESSIBLE SERVICES AND THE
AMERICANS WITH DISABILITIES ACT

Individuals, who cannot board, ride or get to or from 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, origin-to-destination, shared-ride accessible paratransit throughout its service area.

TEL•A•RIDE drivers can assist passengers from their residence to the vehicle or from the vehicle to their destination point upon request. Please remember to make this request when making your reservation.

If the effects of your disability 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. After 21 days presumptive (If a decision is not made within 21 days service will be provided until a decision is made.)

If you do not agree with the decision, you have a right to appeal. Appeals information will be sent to you, if your request for eligibility is denied. 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. #: ________________ Zip: ________________

City: __________________________

Mailing Address (if different from home):

________________________________________________________________________

Apt. #: ________________ Zip: ________________

City: __________________________

Daytime Phone: ( ) ____________________ TDD/TTY: ( ) ____________________

Evening Phone: ( ) ____________________ Cell Phone: ( ) ____________________

Birth Date: __/__/_________ ☐ Male ☐ Female

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: ( ) ____________________
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)
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 ___ Not Sure (please explain)
   
   Explain: _____________________________________________________________

2. Does the weather affect your ability to travel outside and use the bus service?
   
   ___ Yes ___ No ___ Sometimes ___ Not Sure (please explain)
   
   Explain: _____________________________________________________________

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 ___ ¾ mile (9 blocks)
   ___ ¼ mile (3 blocks) ___ No
   ___ ½ mile (6 blocks) ___

4. Are you able to climb three 12-inch steps without assistance?
   
   ___ Yes ___ No ___ Sometimes ___ Not Sure (please explain)
   
   Explain: _____________________________________________________________

5. Are you able to wait outside without support for up to fifteen minutes?
   
   ___ Yes ___ No ___ Sometimes ___ Not Sure (please explain)
   
   Explain: _____________________________________________________________

6. Are you able to give addresses and telephone numbers upon request?
   
   ___ Yes ___ No ___ Sometimes ___ Not Sure (please explain)
   
   Explain: _____________________________________________________________

7. Are you able to recognize a destination or landmark?
   
   ___ Yes ___ No ___ Sometimes ___ Not Sure (please explain)
   
   Explain: _____________________________________________________________

8. Are you able to ask for, understand, and follow directions?
   
   ___ Yes ___ No ___ Sometimes ___ Not Sure (please explain)
   
   Explain: _____________________________________________________________

9. Are you able to deal with unexpected situations or changes in routine?
   
   Explain: _____________________________________________________________
10. Are you able to independently travel through crowded and/or complex facilities??
   Yes   No   Sometimes   Not Sure (please explain)
   Explain: ________________________________

11. Can you get to and board the TEL-A-RIDE vehicle without the help of another person?
   Yes   No   Sometimes   Not Sure (please explain)
   Explain: ________________________________
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 _______________________________
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. 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
   If No, Explain: ________________________________________________
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 □ Sometimes □ Not Sure
   Recognizing a destination or landmark? □ Yes □ No □ Sometimes □ Not Sure
   Ask for, understand and follow directions? □ Yes □ No □ Sometimes □ Not Sure
   Safely and effectively travel through crowded facilities? □ Yes □ No □ Sometimes □ Not Sure

7. If the applicant has a disability affecting mobility is the applicant able to:
   
   Wait outside without support for 10 minutes? □ Yes □ No □ Sometimes □ Not Sure

8. Is the applicant's ability to independently travel to a fixed-route bus stop 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  State

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
5790 Casper Padgett Way
North Charleston, SC 29405

If you have any questions about the completion of this application please call the ADA Coordinator at 843-529-0400.

**Applicant must complete:**

- All information, Part I, Pages 1-7
- Applicant Signature, Part I, Page 7E
- Signature of the 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