APPLYING FOR ADA CARTaccess SERVICE

In compliance with the Americans with Disabilities Act of 1990 (ADA), CARTaccess provides ADA Priority Service to anyone with a disability who cannot use the fixed-route bus system. If your disability prevents you from using a lift-equipped CART bus some or all of the time, you may be eligible for CARTaccess ADA service.

Applying for ADA service is a two-step process. Both steps are necessary to complete the certification process.

1. **Application completed for person applying for ADA service**: It is important to complete all parts of this application. Incomplete applications will be rejected, which will delay the eligibility process. Please print.

2. **Health-care Professional Verification form completed by a treating licensed professional**: A Health-care Professional Verification form must be completed by a treating professional who knows your disability(s). A licensed professional must complete this form. This licensed professional may be a doctor, nurse, social worker, occupational therapist, rehabilitation worker, etc.

**IMPORTANT**: Both documents must be completed and returned to CARTaccess or your certification will be considered incomplete which will delay the eligibility process. Upon completion of the certification process, CARTaccess will notify you within 21 days by mail the decision made on your eligibility. If you have questions, please phone (405) 325-5438.

**Please note**: If you qualify for service, you are encouraged to have an ADA ID card made. There is no charge for the card. The office staff will take a photograph of you and the ID card will be mailed to your residence. Phone (405) 325-5438 for more information.

Thank you for your cooperation,

Connie Bratt
Paratransit Specialist Supervisor
PART 1 GENERAL INFORMATION ABOUT APPLICANT

☐ Male   ☐ Female

First Name: ___________________________________________ MI: __________
Last Name: ____________________________________________
Street Address: _______________________________________ Apt No. _____
Nearest Cross Street to Your Address: ____________________________
City: __________________________ State: _____ Zip Code: __________
Date of Birth: ____________________________________________
Home Phone: (_____)(___________) Mobile: (_____)(___________)
E-mail address: ______________________________________________

Mailing address (If different from above): __________________________
City: __________________________ State: _____ Zip Code: __________

If an OU employee/student, what is your 9-digit ID number:___________

Please give us the name and phone number of an emergency contact.

First Name: __________________________ Last Name: ______________________
Phone: (_____)(___________) Relationship: ____________________________

Did someone help you fill out this application?  ☐ Yes  ☐ No
First Name: __________________________ Last Name: ______________________
Phone: (_____)(___________) Relationship: ____________________________
PART 2 INFORMATION ABOUT APPLICANT’S DISABILITY

Please read the following statements and check the ONE that best describes your disability or condition.

☐ I have a temporary disability and will only need CARTaccess until I recover.

☐ I have difficulty remembering all of the things I have to do when using the fixed-route CART bus.

☐ I have a disability(s) that caused me to have good day(s) and bad day(s).

☐ I believe I can learn to ride the CART bus if someone taught me.

☐ I have a visual disability which prevents me from using the CART bus.

☐ I can use CART for some trips but not others.

☐ I am able to ride CART independently.

☐ I can never use the CART bus by myself.

1. What is your disability(s)? Please list all disabilities that prevent you from using fixed-route bus service.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

2. How does your disability(s) prevent you from using fixed-route bus service? Please explain.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

3. Is the disability described above temporary or permanent?

☐ Temporary. I expect the disability to last _____ months.

☐ Permanent

☐ I don’t know
PART 3  INFORMATION ABOUT APPLICANT’S MOBILITY AIDS

4. Please indicate if you use any of the following mobility aids or equipment.

- [ ] None
- [ ] Long White Cane
- [ ] Scooter
- [ ] Manual Wheelchair
- [ ] Portable Oxygen
- [ ] Electric Wheelchair
- [ ] Leg Braces
- [ ] Cane
- [ ] Service Animal (describe) ________________________________
- [ ] Walker
- [ ] Other ________________________________

4a. If you use a wheelchair, what is the combined weight of you and your wheelchair? _______ pounds

**NOTE:** If your wheelchair or scooter is longer than 48 inches or wider than 32 inches, or if your total weight with your wheelchair is more than 600 pounds, contact the CARTaccess office for evaluation.

4b. How far can you travel using your wheelchair or scooter?

- [ ] 0-1 block
- [ ] 2 blocks
- [ ] 3 blocks
- [ ] 4 blocks
- [ ] 5 blocks
- [ ] 6 blocks
- [ ] 7 blocks
- [ ] 8 blocks or more

5. Do you require the assistance of a (PCA) Personal Care Attendant when you travel?  

- [ ] Yes  
- [ ] No

How do they help you? ____________________________________________

________________________________________

PART 4  INFORMATION ABOUT APPLICANT’S ABILITIES

6. What form of transportation do you currently use?

- [ ] Fixed-route bus service
- [ ] Drive yourself
- [ ] Someone drives you
- [ ] Other ________________________________
7. Does your disability or condition change from day to day in a way that makes it very difficult to use the fixed-route buses?
   - Yes  
   - No  
   If yes, please explain ________________________________

8. Does weather keep you from using fixed-route buses due to your disability(s)?
   - Yes  
   - No  
   If yes, please explain ________________________________

9. When crossing a street what do you look or listen for?
   - Do not cross streets without assistance
   - Listen for traffic sounds
   - Look for a crosswalk signal
   - Look for traffic and cross when safe

10. Are you able to locate the appropriate bus stop to complete your trip?
    - Yes  
    - No  
    If no, please explain ________________________________

11. How far can you travel on your own or with a mobility aid?
    - I can’t travel outside my house
    - I can get to the curb of my house
    - I can travel up to 1 block
    - I can travel up to 2 blocks
    - I can travel up to 3 blocks
    - I can travel up to 4 blocks
    - I can travel up to 5 blocks
    - I can travel up to 6 blocks
    - I can travel up to 7 blocks
    - I can travel up to 8 blocks

12. Do any of these barriers prevent you from using the fixed-route bus service? (Check all that apply)
    - None
    - Hills
    - Lack of curb cuts
    - Lack of sidewalks
    - Uneven surfaces
    - Rough Terrain
    - Other ________________________________
13. Do you have a vision problem that would prevent you from using the fixed-route buses?

- Yes  - No  

If yes, check all that apply:

- Restricted fields  - Legal blindness  - Total blindness
- Light sensitivity  - Night blindness

Please explain: ____________________________________________________________

14. Are you able to independently get to and from a bus stop?

- Yes  - No  - Sometimes

If no or sometimes, please explain: ____________________________________________

15. Are you able to independently transfer between fixed-route buses to reach your destination?

- Yes  - No  - Sometimes

If no or sometimes, please explain: ____________________________________________

16. Are you able to get on and off the fixed-route bus?

(Note: All CART buses have a wheelchair lift or ramp and many have kneeling capability which lowers the height of the entry. Passengers who find the bus entry/steps too high may enter and exit the bus using the wheelchair lift or ramp.)

- Yes  - No  - If no, please explain ________________________________

17. What would you do if you found yourself at the wrong place?

- Phone home
- Ask someone for assistance
- Don’t know
- Panic
- Other
18. How do you communicate your needs to the driver?

- Verbal
- Visual
- Sign
- Unable

19. Are you able to do the following? (Check all you CAN do)

- Ask for, understand, and follow directions
- Tell what time it is
- Recognize a destination landmark
- Use a telephone to make and receive calls
- Give address and telephone number

Part 5  YOUR EXPERIENCE USING FIXED-ROUTE BUSES

20. Have you taken the fixed-route bus independently before?

- Yes
- No

20a. If yes, when? ____________________________

20b. If you have not taken the fixed-route bus before, why?
(All CART buses are equipped with lifts or ramps for ADA access)

- I do not know how to get bus information
- For cognitive reasons, unable to navigate the bus system
- Unable to read information (language barrier excluded)
- Cannot get to the bus stop
- Other (explain) ____________________________

21. Do you now use fixed-route buses on your own?

- Yes
- No
- Sometimes

If yes or sometimes, check all that apply:

- I use route(s) #_________________________ for simple, direct trips.
- I use route(s) #_________________________ for complex trips using transfers.

22. Have you ever received travel or mobility training for using the CART system?

- Yes
- No

22a. If yes, to/from

- School
- Workshop
- Work
- Shopping
- Other

Please explain ____________________________
23. Is there any additional information you would like to share regarding your disability or condition that prevents you from using the fixed-route bus service?

[ ] No  [ ] Yes, please explain __________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

24. To evaluate your request, CARTaccess will contact your licensed health-care provider. It is your responsibility to provide CARTaccess with his/her complete and accurate mailing address. Incorrect information will result in a delay.

Name of licensed health-care provider ________________________________________________

Address _____________________________________________________________________________

City __________________________ State __________ Zip Code _______________________________

Phone __________________________ Fax ________________________________________________

Applicant’s Name (please print) ________________________________________________________

Applicant’s Signature _________________________________________________________________

Date _____/____/____

25. Acknowledgement of responsibility. I agree that I will pay the exact fare for each trip. I agree to notify CARTaccess office at 325-5438 of any changes in my status which may affect my eligibility to use the service. I understand that failure to adhere to the policies and procedures will be grounds for revoking my certification. I understand and agree not to hold CART, the University of Oklahoma or the City of Norman responsible for all claims or liability for damages to any person, property or personal injury occurring as a result of my failure to equip or maintain the safety measures of the adaptive equipment or certified service animal that I require for mobility. I have read and fully understand the conditions for service outlined above and agree to abide by them.

Applicant’s Signature _________________________________________________________________

Date _____/____/____
By signing this form I understand I am giving consent for CART to use and disclose my protected health information for the following purpose and activities:

1) To transfer information to medical professionals for review, transportation providers and mobility services.

2) Permission to contact my health-care provider to verify my disability and treatment plan for purposes of paratransit eligibility.

3) The information provided is true and correct to the best of my knowledge. I understand that falsification of information will result in denial of service.

CART appreciates your cooperation in this process and assures you that your protected health information will be kept strictly confidential, following HIPAA (health insurance portability and accountability act) guidelines.

Name ____________________________________________________________
(Or legal guardian if under 18 years old)
Signature __________________________________________________________
Date _____ / ____ / ____

Mail completed application to CARTaccess at:

CARTaccess
ADA Certification
510 E. Chesapeake
Norman, OK 73019-5128