

Washington County Transit (WCT)
County Commuter
1000 W. Washington St. Hagerstown, MD 21740
Phone 240-313-2750
Fax 301-791-3343
www.washco-md.net

**APPLICATION FOR PARTICIPATION
IN THE COUNTY COMMUTER'S
ADA COMPLEMENTARY
PARATRANSIT PROGRAM**

This information will be used to determine transportation services eligibility and may be shared with other transit service providers. The information will be kept confidential in accordance with State law. **Providing false information may constitute a crime punishable by law.**

After we receive your completed application, it will be reviewed within 21 days from the date your application was received and you will be notified by mail if you have been certified to use the paratransit services. Applicants **may be required** to have an In-person interview or may be referred to a medical facility for functional assessment as part of the certification process.



SECTION 3 – TRAVEL ASSISTANCE:

If you are found eligible for County Commuter’s Paratransit Program, WCT will use the following information to plan your trip properly and reserve the proper vehicle for your ride.

Check below if you use any of the following:

Manual (standard) wheelchair _____ Power wheelchair _____ Scooter _____
Cane _____ Crutches _____ Walker _____ Service animal _____ Oxygen _____
Other (please describe) _____

If you use a wheelchair, can you transfer to a car with a little help? Yes _____ No _____

For your safety, comfort and convenience, please state the specifications of your wheelchair:

Length of wheelchair: _____ in. Width of wheelchair: _____ in.

Combined weight of you and your wheelchair/scooter: _____ lbs.

Do you have a Personal Care Assistant (PCA) that travels with you? Yes _____ No _____ Sometimes _____

Are you currently certified to use any other Paratransit service, such as Medical Assistance (via Washington County Health Dept.), Social Services, Department of Aging, etc.? Yes _____ No _____

Please list all: _____

SECTION 4 – FUNCTIONAL ABILITY: Please answer ALL of the following questions

Are you physically able to:

1. Walk, use wheelchair or scooter, etc. about 1/3 of a city block (200 feet) without help from another person?
Yes _____ No _____ Sometimes _____
2. Walk, use wheelchair or scooter, etc. about three city blocks (1/4 of a mile) without help from another person?
Yes _____ No _____ Sometimes _____
3. Climb three 12-inch steps without help? Yes _____ No _____ Sometimes _____
4. Wait outdoors for a bus without assistance for 15 minutes?
Yes _____ No _____ Sometimes _____
5. Travel to and from your home to fixed-route bus stop?
Yes _____ No _____ Sometimes _____
6. Travel to and from your trip destination to the fixed-route bus stop?
Yes _____ No _____ Sometimes _____
7. Get on and off County Commuter lift-equipped bus without help?
Yes _____ No _____ Sometimes _____
8. Use County Commuter fixed-route bus transportation in one direction and Paratransit service in the other direction? (Example: travel to dialysis by fixed-route bus but return using Paratransit service)
Yes _____ No _____ Sometimes _____
9. Do you currently use any of County Commuter’s other transportation services?
Fixed-Route: Yes _____ No _____ Sometimes _____
Taxi Voucher: Yes _____ No _____ Sometimes _____
JOBS Shuttle: Yes _____ No _____ Sometimes _____

SECTION 5 – VERIFICATION:

I hereby certify, under the penalties of perjury, that the information given above is true and correct. I understand that WCT will rely upon this information in making a determination as to my eligibility for participation in the program. I agree that if any of the information given the WCT is materially false or misleading, WCT shall have the right to revoke or condition my right to participate in the Paratransit program, in addition to pursuing any other right or remedy which WCT may have.

Signature _____ Date ____/____/____

SECTION 6 – APPLICATION ASSISTANCE:

If you have completed this application for someone else seeking certification please give the following information:
(Please print)

Name _____

Address _____

City _____ State _____ Zip code _____

Daytime phone _____

Signature _____ Date ____/____/____

THE FOLLOWING SECTION IS TO BE COMPLETED BY APPLICANTS PHYSICIAN OR HEALTHCARE PROFESSIONAL:

SECTION 7 – INSTRUCTIONS:

In deciding whether the applicant is eligible for the Program, WCT will consider input from the applicant’s healthcare provider as well as other information.

In general, to qualify for the WCT Paratransit Program, an individual must have a disability and be unable, as a result of physical or mental impairment, to board, ride or exit from any accessible WCT fixed-route vehicle. The fact that the applicant’s medical condition makes using the public transit system more difficult is not a basis for eligibility for the Program. Therefore, focus your response on the **functional ability of the applicant**. Applicants **MAY** be referred to a medical facility for functional assessment as part of the certification process. If a person is Paratransit eligible for some trips but not others, please specify any limitations. If an individual has a temporary medical condition, please provide information as to the duration of that medical condition.

Low income is not a factor in determining an applicant’s Paratransit eligibility.

Please print client’s name and answer all questions completely in your professional opinion.

Client’s name _____

1. Does this client have a need for curb-to-curb Paratransit service? Yes ____ No ____ Sometimes ____

2. Please describe the circumstances in which you feel the applicant would not be able to use the fixed-route bus system: _____

3. Can the client, with the assistance of wheelchair lift or other boarding assistance device, board, ride and exit a WCT fixed-route vehicle? Yes _____ No _____

4. The medical condition which prevents the applicant from using the system is expected to be:
 Permanent _____ Temporary _____ If temporary, please state when the condition is expected to be resolved: _____

5. Does the applicant's medical condition make it necessary that a Personal Care Assistant (PCA), anyone designated by the individual to help meet his or her personal needs, accompany the person when using Paratransit service? Yes _____ No _____ If yes, please describe why: _____

I certify that the information I have submitted is my true and accurate medical opinion.

 Printed name of physician/healthcare professional

 Physician/healthcare professional's signature

 Address

 City

 State

 Zip Code

 Telephone

 Fax

Applicants who do not qualify for Paratransit service may be eligible for reduced fares on regular fixed-route service or may qualify for the Ride Assist Voucher Program.

For more information, please call 240-313-2750 or Maryland Relay Service (711), for those who are hearing and/or speech impaired.

Please complete and mail, fax or drop off at the County Commuter office.

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