



## **MAT-SU COMMUNITY TRANSIT**

### **ADA Transportation Application**

Mat-Su Community Transit, or MASCOT, offers ADA paratransit service and deviations to the fixed-route for people with physical, cognitive or sensory disabilities that prevent them from using the regular fixed-route bus system. Disability alone does not qualify an individual for deviations nor for ADA paratransit service. Eligibility is based on the applicant's functional capabilities.

The Americans with Disabilities Act (ADA) requires that ADA paratransit service and deviations be provided only to those people whose disability prevents them from getting to and from and/or boarding the fixed-route system. Therefore, all people seeking eligibility for the ADA paratransit services must go through an eligibility determination process.

In order to apply for eligibility for paratransit, demand-response, deviations to the fixed-route system, and/or other transportation services through MASCOT, you must do the following:

1. Complete and sign the ADA Transportation Application. Answer all questions or the application will be considered incomplete and returned to you.
2. Participate in an in-person Transportation Skills Assessment upon notification to do so.
3. Complete the Medical Verification Release upon request.

Once the transportation skills assessment is complete and medical verification has been received, a determination of your eligibility will be made within 21 days. You will be notified of your eligibility by mail.

***People who need assistance to complete the application may call the MASCOT office at (907) 376-5000.***

## ADA Paratransit Eligibility Determination

Those people who are determined eligible for ADA paratransit service will be given one of the following, based upon their functional capabilities.

**Full Eligibility:** There will be no restrictions to deviations and/or paratransit service within the program guidelines.

**Temporary Eligibility:** Deviations and/or paratransit service will be provided to people who are determined capable of using accessible MASCOT bus service, but have a temporary need for paratransit service.

**Conditional Eligibility:** Deviations and/or paratransit service will be provided for certain trips for which it is determined that the person's disability prevents him or her from using MASCOT bus service independently.

**Transitional Eligibility:** Deviations and/or paratransit service will be provided until the person is successfully travel trained for certain trips using MASCOT bus service independently.

## Appeal Process

Applicants who are determined not eligible, or who do not agree with the conditions established for their use of ADA transportation may request a review of their eligibility by an appeal committee. Information regarding the appeal process is provided when an applicant receives notification of eligibility.

### Where to send the application, or to ask questions?

Return the application by mail or fax. We are happy to answer any questions.

**Fax:** (907) 373-5999

**Mail:** MAT-SU COMMUNITY TRANSIT

PO Box 871590

Wasilla, AK 99687

**E-mail:** [dispatch@matsutransit.com](mailto:dispatch@matsutransit.com)

**Call:** (907) 376-5000

This publication can be made available in alternate media formats by request.

**PLEASE FILL OUT ENTIRELY OR THE APPLICATION PROCESS WILL BE DELAYED. THE APPLICATION CONTAINS EIGHT (8) PAGES.**



# Mat-Su Community Transit ADA Transportation Application

Office Use Only -		
Received: _____	MASCOT needed to perform assessment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Appointment Date: _____	Time: _____	Comment: _____
Rescheduled Date: _____	Time: _____	Comment: _____
Final Appointment: _____	Time: _____	Comment: _____

**All questions must be answered before your application will be considered.  
Incomplete applications will be returned and will delay the process.**

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

Residence Address: Street \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext. \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security # (Last 4 digits): \_\_\_\_\_

Sex:  Female  Male

### Emergency Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

# ADA Applicant Information

1. Are you a: Current Paratransit Rider New Applicant Visitor

2. Do you need information given to you in any of the following formats?  
Large Print Audio Tape Braille Computer Diskette None

3. What type of impairment or limitation prevents you from using the Fixed-Route bus service?  
(Check all that apply.)  
None Physical Disability Developmental Disability  
Mental Illness Brain Injury Visual  
Legally Blind Totally Blind  
Other (explain): \_\_\_\_\_

Medical/Clinical Diagnosis(s): \_\_\_\_\_

Briefly explain how the impairment(s) or limitation(s) prevent you from using the Fixed-Route bus service. \_\_\_\_\_

4. (a) Is your disability or health condition Permanent Weather related  
Temporary; expected to last until \_\_\_\_\_  
Varies. Please explain. \_\_\_\_\_

(b) Can you stand outside without support for 15-30 minutes? Yes No

5. Please indicate the primary mobility aids you use when traveling in the community:  
Support Cane Leg Braces Picture Board  
Long White Cane Crutches Alphabet Board  
Low Vision Aid Walker Powered Wheelchair  
Hearing Aid Powered Scooter Manual Wheelchair  
Other (specify) Prosthesis Oxygen Tank  
Service Animal None

What type of animal? \_\_\_\_\_

What function does the service animal provide regarding your transportation?  
\_\_\_\_\_

Is the animal certified? Yes No

6. If a wheelchair or scooter is used, does it meet the following conditions for our vehicles? Not greater than 30 inches wide and 48 inches long when measured 2 inches above the platform base, and does not exceed 600 pounds when occupied by applicant.

Yes No

7. Do you require a Personal Care Attendant (PCA) to help you travel? A PCA is a person provided by you to help with your daily needs.

- Never      Sometimes      Always

8. Have you applied for paratransit before? Yes No

If yes, how has your condition changed? \_\_\_\_\_

9. How are you currently traveling? Family/Friends Cab Bus Other \_\_\_\_\_

10. Check the items listed below that might help you ride the Fixed-Route bus system:

- Help with trip planning      Bus stops closer to my house  
Help communicating      Other  
Someone to teach me      None

11. Can you climb three steps with a hand rail, without assistance?

- Yes      No      Do not know

12. (a) Have you ever used Fixed-Route buses?

- No      Yes, I have used other buses      Yes, I currently use MASCOT  
Yes, but I can't any longer due to: \_\_\_\_\_

(b) Has anyone ever taught you how to use MASCOT buses?

- No      Yes, from a friend/relative  
Yes, from an agency (Name): \_\_\_\_\_

Did you complete the training? Yes No When \_\_\_\_\_

Check the skills you were able to learn:

- To travel to and from bus stops      To ride all or some routes  
To cross streets      To read bus schedules  
To ride the routes listed: # \_\_\_\_\_ # \_\_\_\_\_ # \_\_\_\_\_  
Other

(c) Have you used public buses in another city or cities?

- No      Yes, I have used other buses  
Yes, but I can't any longer due to: \_\_\_\_\_

(d) What is the closest bus route to your home? Route # \_\_\_\_\_ I don't know

13. Living arrangements:

- Family/Friend      Nursing Home      Supported/Assisted Living  
By Yourself      Group Home      Other (Specify)

14. What agencies are you currently associated with? \_\_\_\_\_

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

15. What agencies or persons are allowed to represent you, and exchange information with MASCOT on your behalf? (List names & phone numbers)

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

16. (a) Are you on general Medicaid? Yes No

(b) Are you currently on a Medicaid waiver option? Yes No

If yes, Care Coordinator Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_



I, \_\_\_\_\_ have received a copy of the MASCOT / Valley Rides rider guide.

\_\_\_\_\_  
Sign

\_\_\_\_\_  
Date

# Applicant Verification

## Part A. Applicant Signature

I understand that the purpose of this application form is to determine if there are times when I cannot use MASCOT bus service independently and will require paratransit service and/or deviations to the fixed-route system. I understand that the information on this application will be kept confidential and shared only with the professionals involved in evaluating my eligibility. I certify, to the best of my knowledge, the information on this application is true and correct. I understand that providing false or misleading information could result in my eligibility status being terminated. I give permission for MASCOT to contact the professional who has filled out this application or given supplemental verification of my condition.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Part B. Person completing this form if other than Applicant (check one):

- I certify the information in this application is true and correct based upon the information given to me by the applicant.
  
- I certify that the information provided in this application is true and correct based upon my own knowledge of the applicant's health condition or disability and that I have legal authority to complete this application.

Exceptions or Additions:

---

---

Print Name: \_\_\_\_\_ Day Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_ Agency: \_\_\_\_\_

## **Release for Medical Verification**

**It may be necessary to contact a physician or other professional to confirm the information you have provided. Please complete the following authorization.**

The following Professional is familiar with my disabling condition(s) and is authorized to provide information to MASCOT to complete my ADA paratransit certification.

**(check one):**  **Physician**  **Health Care Professional**  **Rehabilitation Professional**

Professional's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_ Mailing Address: \_\_\_\_\_

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE FILL OUT FORM ENTIRELY OR APPLICATION  
PROCESSING WILL BE DELAYED.**