

LORAIN COUNTY TRANSIT

**AMERICANS WITH DISABILITY ACT (ADA) APPLICATION**

The attached application must be completed by individuals who wish to apply for eligibility for the ADA Dial-A-Ride Program, curb-to-curb service.

**To Apply for ADA Eligibility:**

1. Applicants must fill out pages **1-6 COMPLETELY**. The medical professional or social worker **must complete page 7.**
2. The application is then mailed or faxed to:  
  
Lorain County Transit  
Attn: ADA Coordinator  
226 Middle Avenue  
Elyria, OH 44035  
Fax: (440) 323-3357
3. You will be notified of your ADA eligibility status within 21 working days of the date that we receive your **completed** application.
4. Upon completion of the process a LCT ADA I.D. card will be issued.

**All applications that are not entirely and correctly completed will be returned to the applicant and not processed.**

To replace a Lost or Stolen ADA I.D. card:

1. You must come to LCT's Administrative Office – 226 Middle Avenue, 4<sup>th</sup> Floor, Elyria.
2. **A photo I.D. is required for replacement of your card.**
3. There is a \$5.00 replacement fee for lost or stolen cards.



**PART II: INFORMATION ABOUT YOUR DISABILITY**

What is/are your disability/disabilities? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your disability prevent you from using the fixed route bus service by yourself? Yes No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you need someone to accompany you to travel outside the home (example – personal care assistant)?  
Yes No

If yes, how often? \_\_\_\_\_

Have you had a disability for more than one year? Yes No

Is your disability considered permanent? Yes No

If no, how long do you expect to have a disability? \_\_\_\_\_

Does your disability change from day to day? Yes No

If yes, please explain: \_\_\_\_\_

Do you use a mobility aid? Yes No If yes, please circle all that apply to you:

Manual Wheelchair

Motorized Wheelchair

Scooter

Service Animal (Guide Dog)

Cane

Crutches

Brace(s)

Walker

Portable Oxygen

White Cane

Other (please specify): \_\_\_\_\_

**PART III: INFORMATION ABOUT YOU'RE YOUR CURRENT USE OF  
THE FIXED ROUTE BUS SERVICE**

**Please Check All That Apply**

- I ride the bus frequently.
- I ride the bus sometimes, if the conditions are right.
- I ride the bus when I am feeling well.
- I can only ride the bus if they have a wheelchair lift or low floor.
- I have a vision impairment that prevents me from ever getting to and from the bus, even with training.
- I could learn to use the bus if someone taught me.
- I am not sure if I can use the bus service.
- I can never use the bus service by myself.
- I have no bus service in my area.
- I am not able to use the bus service for other reasons. Please explain:  
\_\_\_\_\_

- I don't like to use the fixed route bus service.

Do you currently use the fixed route service? Yes No

If yes, which routes do you use? \_\_\_\_\_

If yes, do you need the assistance of another person and what aid does that person perform for you?  
\_\_\_\_\_

If yes, is there anything about riding the bus that is difficult for you?  
\_\_\_\_\_

Have you ever used the fixed route bus service? Yes No

If yes, why did you stop? \_\_\_\_\_

Which bus routes service your home neighborhood? \_\_\_\_\_

What is the closest bus stop to your home? (Please give an intersection)

Can you get to the bus stop nearest to your home by yourself? Yes No

If no, what not? \_\_\_\_\_

Can you cross any street by yourself? Yes No

If yes, what types of streets? \_\_\_\_\_

If no, please explain: \_\_\_\_\_

Are you able to grasp handles or railings, coins or tickets while boarding or exiting the bus? Yes No

If no, please explain: \_\_\_\_\_

Can you understand and follow directions to get you to your destination? Yes No

If no, please explain: \_\_\_\_\_

Does weather affect your ability to use the bus system? Yes No

If yes, please explain: \_\_\_\_\_

Have you ever received training on how to use the bus system? Yes No

If yes, which agency provided the training? \_\_\_\_\_

When was the training provided? \_\_\_\_\_

Did you successfully complete the training? Yes No

Would you like to receive travel training? Yes No

**PART IV: APPLICANT'S CURRENT TRAVEL**

How would you describe the terrain where you live? (e.g., flat, steep hills, gradual sloping hills, etc.)

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Are there sidewalks in your neighborhood? Yes      No

List the last 5 most frequent destinations you traveled to and how many times you traveled there and how you got there:

Destination Address / How Often / How do you get there now?

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**PART V: APPLICANT CERTIFICATION**

I understand that the purpose of this application is to determine if I am eligible for LCT's ADA Dial-A-Ride service and that LCT staff may need to talk to me later to get more information. Additionally, I understand that I may be required to attend an in-person interview or functional ability assessment as part of this application process.

By signing this application, I certify that I have been truthful in answering this form and that the information that I have provided is correct to the best of my knowledge. I understand that falsification of this information could result in a loss of ADA Dial-A-Ride service.

I agree to notify LCT if I no longer need to use the ADA Dial-A-Ride service;

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Signature

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Date

**PART VI: TO BE COMPLETED ONLY IF ANOTHER PERSON HELPED  
THE APPLICANT IN THE COMPLETION OF THIS FORM**

Name of person giving assistance: \_\_\_\_\_

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

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

Phone (Home/Cell): \_\_\_\_\_ (Work): \_\_\_\_\_

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

**PART VII: APPLICANT AUTHORIZATION FOR  
RELEASE OF MEDICAL INFORMATION**

I authorize the professional listed below to release to LCT information about my disability and health condition and its effect on my ability to travel on LCT buses. I understand that I may revoke this authorization at any time.

All medical information, which you or your health care professional provide, will be kept confidential to the extent permitted under the law except that the information may be shared with other professionals or agencies involved in the determination of your eligibility.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Health Care Professional: \_\_\_\_\_

Office Address: \_\_\_\_\_

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

PART VIII: MEDICAL PROFESSIONAL CERTIFICATION

TO BE COMPLETED BY YOUR LICENSED PHYSICIAN, SOCIAL WORKER  
OR HEALTH CARE PROFESSIONAL. PLEASE PRINT.

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

Office Address: \_\_\_\_\_

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

Office Telephone Number: \_\_\_\_\_

License/Certification No.: \_\_\_\_\_ State: \_\_\_\_\_

Profession: *Please check:*

\_\_\_\_\_ Physician          \_\_\_\_\_ Social Worker

\_\_\_\_\_ Other, please specify: \_\_\_\_\_

**Must initial** each statement to which you agree:

\_\_\_\_\_ I certify that I have treated the Applicant and am familiar with his/her disability and health condition.

\_\_\_\_\_ I certify that I have read and agree with the Applicant's information in its entirety.

\_\_\_\_\_ I certify that the Applicant is UNABLE to ride LCT's fixed route bus services.

Why is applicant unable to use fixed route bus service? Please explain in detail: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If condition is not permanent, please indicate duration: \_\_\_\_\_

I understand that false certification may be reported to the licensing jurisdiction under the State of Ohio or appropriate code for state of license/certification.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date