ADA PARATRANSIT

TEMPORARY ELIGIBILITY REQUEST

MATERNAL AND INFANT HEALTH COMMITTEE (M.I.H) INITIATIVE

You have requested temporary eligibility for Access Link as a part of an initiative in collaboration with the New Jersey's Maternal and Infant Heath Committee. This initiative is **strictly** reserved for customers presenting with an immediate short-term need for transportation assistance due to a disability or impact of serious health condition related to pregnancy.

As required by the Americans with Disabilities Act (ADA), the presenting disability or health condition must be impacting a major life function and preventing you from using NJ TRANSIT's local fixed-route system to travel. In order for your request to be considered you must provide all required information. This application can also be submitted to NJ TRANSIT via fax 973.609.1800 or email at ADACERT@njtransit.com.

Our goal is to process this request within one (1) business day, when possible.

Do you have a legal guardian? ☐ No ☐ Yes If yes, your legal guardian must provide his or her written consent for you to participate in this process.

Legal Guardian Name (PRINT)______________________________

Signature ________________________ Date ______________

Name: Ms. Mrs. ____________________________

Home Address: ____________________________

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Type of Street: ☐ Cul-De-Sac ☐ Dead End

We may need to evaluate addresses to determine if there are environmental or geographic concerns that would prevent an Access Link vehicle from performing an origin to destination ride.

Mailing Address: ____________________________

(If same as above leave blank)

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Home Phone ________________________ Cell ________________

Date of Birth ______________ Email_____________________________

Please provide the name of someone who you authorize NJ TRANSIT to contact in the event of an emergency.

Name ________________________ Phone______________

Relationship___________________

1. What is your temporary disability? _____________________________
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2. Which of the following are impacted by your temporary disability? (*check all that apply)*

☐ Physical Ability ☐ Cognitive Ability ☐ Vision ☐ Hearing

3. What is the expected duration of your temporary disability?
from: ______________to: ____________.

4. How are the conditions and limitations related to your temporary disability preventing you from using the local fixed-route system to travel to and/ or from your intended destinations?________________________________
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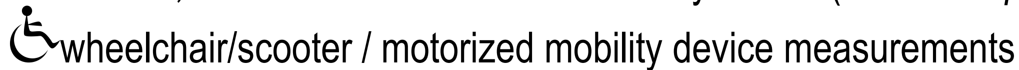
5. Which, if any, of the following mobility or assistive devices do you use while traveling?

- ☐ Orthopedic Cane
- ☐ Braces
- ☐ Manual Wheelchair
- ☐ Scooter
- ☐ Crutches
- ☐ Motorized Wheelchair
- ☐ White Cane
- ☐ Walker
- ☐ Service Animal
- ☐ Oxygen
- ☐ None

6. We require the measurements and approximate weight of your manual wheelchair, scooter and/or motorized mobility device (*while occupied*).


wheelchair/scooter / motorized mobility device measurements

Width _____"

Total Length _____"

Combined weight of customer and mobility devices* _____lbs

*Mobility devices exceeding 30"X 48" or more than 600 lbs. may not fit on our vehicle lifts.

7. Do you require the assistance of another person (besides the trained driver) while traveling? ☐ Yes ☐ No

If yes, what assistance will this person provide for you while you are traveling? ____

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8. Do you require information sent to you in an alternative format? If so, select one of the following:

☐ Large Print ☐ Audio-Tape

9. You may be required to have a medical doctor verify your present temporary medical condition. If required, please have a medical verification faxed to 973.609.1800. This verification must:

- be dated within the past 12 months
- verify your medical conditions
- verify the expected duration of your temporary disability
- be on the health care professionals' letterhead
- be signed by the health care professional

10. Please provide the addresses for where you intend to travel. *All address must be within 3/4of a mile of a NJ TRANSIT local bus route. Access Link only travels in the same areas and during the same times as the local fixed-route sytem.*

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To the best of my knowledge, the information that I have provided is accurate. I understand that if my disability is <u>not</u> considered to be temporary I can opt to participate in the full eligibility process for Access Link. The full process includes an in-person interview. The information provided within this request cannot be used to circumvent or by-pass NJ TRANSIT's established process for full paratransit eligibility consideration.

______________________________ ______________

Signature of Customer Date

______________________________ ______________

Signature of Parent or Legal Guardian Date

Once we have received all required information, we will make a determination about your ability to use Access Link while you recover from your temporary disability or medical condition. All ADA paratransit eligibility determinations are communicated in writing.