Rider's Name:

Phone No:

COTA use only		
Received by:		
Date Received:		
	Approved	Disapproved
Date		
Initials		

Caller Box 10007

Saipan, MP 96950

Telephone: 670-664-2682

Fax: 670-664-2692

Email: cnmicallaride@gmail.com

Commonwealth Office of Transit Authority

Application for Eligibility of ADA Paratransit Services

January 2021

If you are 55 years of age or older, believe you have a disability, or a US Military Veteran

... *that prevents you from using regular transportation, please complete this application and return to the address above to determine your eligibility to receive*

ADA Paratransit Services

The Americans with Disabilities Act (ADA) requires comparable public transportation services for person with disabilities who are unable, because of their disability to use a regular transportation.

If you believe you have a disability that prevents you from using the regular public transportation, please complete this application and return it to the address below to determine your eligibility.

It is important that all parts of this application are completed. **You, the applicant, are responsible for the completing the entire application form.**

- COTA will review your application and follow-up as necessary to determine your eligibility for paratransit services.
- COTA will notify you within 15 days of receiving your completed application regarding your eligibility for paratransit services.

If you have not received a determination after 15 days of submitting your application, please call (670) 664-2682. If you are denied eligibility, you have a right to appeal the eligibility decision. Please contact COTA on the appeals process.

Please Return Completed Application Form to:

COTA Administrative Office
Attention: Mr. John DLG. Demapan, Jr.
Suite 216, Marianas Business Plaza
Susupe, Saipan, MP 96950

If you any have questions regarding the eligibility application process, ADA Paratransit Service, or other transit matter, please call (670) 664 – 2682, fax 670-664-2692, send email to cnmicallaride@gmail.com or visit our website at http://www.cota.gov.mp

Commonwealth Office of Transit Authority

Application of ADA Paratransit Service Eligibility

☐ First Time Applying ☐ Renewal ☐ Re-Applying

SECTION 1 : Personal Information

Check 1: ☐Mr. ☐Mrs. ☐Miss ☐Other_____ (Dr./Rev., etc.)

Name:_____ _____ _____
Last First Middle Initial

Mailing Address _____ _____ _____ _____
Address City State Zip Code

Residence Address: _____ _____ _____
Village Street House/Apt.#

Date of Birth:_____(mm/dd/yy)

Phone: (H): _____ (W): _____ (Cell): _____

Email Address:

_____

Emergency Contact:

Name:_____ Relationship:_____ Contact Number:_____

1. Please describe your disability and explain in detail how it prevents you from using regular transportation:_____
   _____
   _____

2. My condition is: ☐ Permanent ☐ Long-Term
   ☐Temporary_____(Expected duration)

3. Are there any other conditions that limit your ability to use the COTA Van?
   ☐ Yes ☐ No If yes, please explain:_____
   _____
   _____

SECTION 2: Mobility Information

Mobility: (Please check all that apply)

☐ Uses Cane ☐ Uses Walker ☐ Uses Crutches ☐ Uses a Service Animal
☐ Need to use lift instead of steps ☐ Requires Portable Oxygen ☐ Other_____

Wheelchair: ☐ Manual ☐ Motorized ☐ Multi-Wheel Scooter

Length and Width:_____

1. Using mobility aid or on your own, how many blocks can you walk on level ground (estimate 1 block = 500 feet)? Number of Blocks:_____
2. Do you require a Personal Care Attendant (PCA) or escort to accompany you when you travel? Yes ☐ No ☐
3. If you checked **YES,** please list the name(s) of your PCA (agency or escort):

   Name:_____Address:_____Telephone: _____

   Name:_____Address:_____Telephone: _____

   Name:_____Address:_____Telephone: _____

4. Does your disability prevent you from getting to or from your house to your driveway? Yes☐ No☐ If **YES,** please explain: (**MUST COMPLETE)**
   _____
   _____
   _____
5. Can you climb three (3) steps without assistance? ☐Yes ☐ No If **NO,** please explain:
   _____
   _____
6. Is your ability to travel or to wait outdoor affected by extreme hot or cold weather conditions? ☐Yes ☐ No If **YES,** please describe conditions you cannot tolerate.
   _____
   _____

7. Are you able to board or disembark from a COTA vehicle with a wheelchair lift? Yes ☐ No ☐ If **NO,** please explain:

   _____
   _____
   _____

8. Are you able to get around independently without assistance?
   Yes ☐ No ☐ If **NO,** please explain:

   _____
   _____
   _____

9. Are you able to ask for, understand and follow directions?
   Yes ☐ No ☐ If **NO,** please explain:

   _____
   _____
   _____

   In order for COTA to evaluate your application, it is necessary to contact a healthcare professional to verify the information that you have provided. Your signature on the following page will provide the authorization.

   Please list the names of a health care professional (licensed physician, therapist, social worker, or nurse, or certified or registered specialist) designated by the applicant, who may be contacted by COTA.

   Name of Health Care Professional: _____
   Office/Mailing Address:_____

   City _____ State _____ Zip Code _____Telephone_____

   I hereby certify that the information provided in this application is correct. I authorize the release of information and photos to the Commonwealth Office of Transit Authority (COTA). I also authorize COTA to contact the health care professional who completed Section 3 of this section to release information regarding my disability to COTA. The information about my disability will be used solely to determine my eligibility for paratransit services.
   Print & Sign: _____ Date:_____

If you are not the applicant but have completed this application on the applicant's behalf, you must provide the following information:

Full name (Print):_____ Telephone: _____

Mailing Address: _____City: _____ State:_____ Zip Code: _____

Relationship to Applicant: _____

I hereby verify that to the best of my knowledge the information given above is correct and can be verified by the applicant's health care professional.

Signature: _____ Date:_____ (mm/dd/yy)

Please give directions and draw a map to your residence in the box provided below.

If you are 55 years old or older please stop here and submit the completed application to COTA

FOR United States MILITARY VETERANS

Please provide a copy of a valid DD FORM 214 for proof of veteran status and another valid ID.

You have now completed the applicant section of the ADA Paratransit Eligibility Form. Please give this entire Application to the Health Care Professional most familiar with your abilities and disabilities

Section 3: Health care – Professional Verification

VERIFICATION OF PARATRANSIT ELIGIBILITY

Health Care Professional Verification of Applicant's Disability and Functional Capabilities

This portion of the application form is to be completed by a Health Care Professional, who is familiar with the applicant's abilities and disabilities, as they relate to their abilities to travel about the community.

The attached applicant has applied for ADA Paratransit Service with the Commonwealth Office of Transportation Authority (COTA). You are being asked to provide information regarding this applicant's disability as it affects their ability to use the regular transportation to move about the community. Please note that all of our vans are lift-equipped for individuals who use wheelchairs, scooters or unable to use the steps.

COTA provided the paratransit (Curb-to-Curb) service to people who cannot use regular transportation. Not all persons with disabilities qualify for paratransit services.

Please assist our office in determining the eligibility state of _____ _____. By reviewing the enclosed application and completing the attached verification of paratransit eligibility form. If you have any

questions regarding ADA Paratransit eligibility, please contact the COTA at (670-664-2276).

I have reviewed the enclosed application, and I Agree/Disagree with the information provided. If you circled disagree, please explain why:

The applicant is unable to use the regular transportation because:

Temporary: Expected duration until _____ (mm/dd/yy)

Long Term: Conditions with potential for improvement or long periods of remission

Permanent: Condition with no expectation of improvement.

I hereby certify that the above information is true. False verification may result in the disqualification of the applicant.

Full name (Print & Sign):_____ Date:_____