PARATRANSIT ELIGIBILITY APPLICATION
CERTIFICATION OF HEALTH CARE PROVIDER

You are being asked by the applicant named in Part A of this application to provide information regarding his/her ability to use the regular fixed-route services provided by the transit systems in the region. For those persons who are not able to use the regular fixed-route services, with the accommodations provided, the transit system may allow them to use paratransit services. The information you provide will allow us to evaluate the request and determine this individual's specific needs. Thank you for your cooperation in this matter.

Please note: All regular fixed-route and connector services available within the region are currently accessible to persons with disabilities who need lift-equipped vehicles, vehicles which kneel to the curb, and/or announcement of bus stops. In order to be eligible for the paratransit services, the individual must be unable to access these services due to conditions which prevent them from getting to or from a fixed-route bus stop, or transferring between vehicles, and/or conditions which prevent them from being able to get on, ride, or get off a lift-equipped vehicle. Individuals for whom performing these tasks is inconvenient or uncomfortable are not eligible for services, and you are asked to verify this information.

It is extremely important that you provide specific information about the individual's functional **limitations** so that eligibility determination can be made.

Please follow these steps to verify this application:

1. Read the applicant's statements provided in Part A in its entirety

2. Fill out Part B completely using the provided Paratransit Eligibility Criteria.

3. Return completed application to applicant within 7 days of receipt (applicant is responsible for returning application to paratransit provider).

4. Be aware that you may be contacted for further information about applicant's abilities.

5. If you have questions, contact the paratransit provider at:

Plumas Transit Systems
711 E. Main Street
Quincy, CA 95971
(530) 283-2538

PART B — CERTIFICATION OF HEALTH CARE PROVIDER

I hereby certify that the applicant qualifies as ADA Eligible based on the aforementioned information.

The disability is:_____Permanent____Temporary until:_____(Date)

Signature:_____Date Signed: _____ Print Name:_____
_____Print Title: _____ Business Address:
_____ City:_____
_____Zip: _____ Phone:
_____Organization/Practice: _____ Type of Practice:
_____

*Please **return this form to the applicant**