



REQUEST FOR CERTIFICATION OF ADA PARATRANSIT ELIGIBILITY

The information obtained in this certification process will be used by the Berks Area Regional Transportation Authority (BARTA) for the provision of transportation services. Information will only be shared with other transit providers to facilitate travel in those areas. The information contained herein will not be provided to any other individual or agency. (PLEASE PRINT ALL INFORMATION)

1. Last Name _____ First Name _____ M.I. _____
2. Address _____
City _____ State _____ Zip Code _____
(IF RURAL ADDRESS - PLEASE SEND DIRECTIONS)
3. Telephone Number (Home) (_____) _____ (Work) (_____) _____
4. Date of Birth _____ Social Security # _____
5. What is the mental or physical disability that prevents you from using our fixed route bus service? (Note: not an architectural (building), curb or landscape Barrier)

Is this condition temporary? _____ If yes, expected duration until _____.

6. How does this disability prevent you from using fixed route service?
Please explain completely. Use an additional sheet if needed.
7. Are there any other effects of your disability of which we need to be made aware?

Note: If the person requesting certification in Question # 1 is 65 years of age or older, please attach a copy of one of the following as required by the Pennsylvania 203 Lottery-Funded Transportation Program: Birth Certificate, Baptismal Certificate, Statement of Age from the Social Security Administration, Passport, Naturalization Papers, PACE ID Card, Driver's License, State Photo ID Card, Veterans Universal Access ID or Resident Alien Card.

THE FOLLOWING INFORMATION WILL BE USED TO ENSURE THAT AN APPROPRIATE VEHICLE IS UTILIZED TO PROVIDE YOUR TRANSPORTATION AND THAT AN ACCURATE ANALYSIS OF YOUR TRIP REQUEST CAN BE MADE BY THE BERKS AREA READING TRANSPORTATION AUTHORITY.

8. Do you use any of the following aids to mobility? (CHECK ALL THAT APPLY.)

**Manual Wheelchair Electric Wheelchair Powered Scooter
Cane Crutches Walker Service Animal**

**9. Do you require a Personal Care Attendant when you travel using transit?
(Please remember that BARTA Special Services provides door-to-door service only.)**

Yes No Sometimes

10. Please answer the following questions:

Can you travel 200 feet without the assistance of another person?

Yes No Sometimes

Can you travel 1/4 mile without the assistance of another person?

Yes No Sometimes

Can you travel 3/4 mile without the assistance of another person?

Yes No Sometimes

Can you climb three 12-inch steps without assistance?

Yes No Sometimes

Can you wait outside without support for ten minutes?

Yes No Sometimes

11. If the client has Medical Assistance (ACCESS), please complete the following:

Recipient # _____

Card Issue # _____

If enrolled in the Health Choices Program, please list the Managed Care

Organization: _____

In order to allow the Berks Area Regional Transportation Authority (BARTA) to evaluate your request, it may be necessary to contact a physician or other professional to confirm the information you have provided. Please complete the following information and authorization form.

12. The following: (Check One)
Physician Health Care Professional Rehabilitation Professional
is familiar with my disability and is authorized to provide information to the Berks Area Regional Transportation Authority (BARTA) that is required to complete this certification.

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____

13. If this application has been complete by someone other than the person requesting certification, that person must complete the following:

Name _____

Address _____

City _____ State _____ Zip Code _____

Daytime Phone _____

Signature _____ Date _____

14. Print Name of Person Requesting Certification:
(Same as Question # 1.)

Name _____

Date of Birth _____

Signature _____

Date _____

15. I hereby certify that the information given above is true and correct to the best of my knowledge.

Signed _____ Date _____

PLEASE COMPLETE ALL THREE PAGES OF THE APPLICATION. APPLICATIONS THAT ARE NOT COMPLETED PROPERLY WILL NOT BE PROCESSED.

OFFICE USE ONLY

Date Received: _____

Approved _____ **Denied** _____

Date letter sent: _____

BARTA Rep. _____

**RETURN COMPLETED FORMS TO:
1700 North 11th Street**



**Reading, PA 19604-1599
Phone - 610-921-2361
Fax - 610-921-0209**