Transportation Management Association of Chester County (TMACC)

7 Great Valley Parkway, Suite 144, Malvern PA 19355-1432 (610) 993-0911

ACCESS TRANSPORTATION APPLICATION

The information obtained in this certification process will be used by the TMACC to determine eligibility for ACCESS ADA Complementary Paratransit transportation services and will be held in the strictest confidence. The ***SCCOOT*** service will cover trips beginning and ending at points within ¾ mile of the fixed route between Oxford Borough and East Marlborough Township. The ***Coatesville Link*** service will cover trips beginning and ending at points within ¾ of the fixed route between Parkesburg Borough and West Brandywine Township.

GENERAL INFORMATION

Name_____ Telephone_____ (home)
Last First Middle

Address_____
Street City State Zip

Emergency Contact (do not list someone who will be on the vehicle with you!) Please include name, relationship, phone. Sex: M F (Circle One) Date of Birth ____/____/____

_____

_____

DESCRIPTION OF DISABILITY

My disability can generally be categorized as: Physical _____ Visual _____ Cognitive _____

Describe the nature of your disability_____
(Please use additional paper if necessary)
How does your disability prevent you from using regular accessible bus service?_____

_____

_____

Can you use the SCCOOT and/or Coatesville Link bus services: _____ with little or no difficulty

____ use only with great difficulty ____ cannot use at all (why?)_____

_____

I use the following mobility aids (Check all that apply).

_____Electric Wheelchair _____Motorized Scooter _____Crutches _____ Trained service animal (explain how animal has been trained to assist you)

_____Walker _____Cane _____Other

_____ _____

Do you require assistance of someone else to travel? _____Yes _____No (Please Explain)

_____

Please fill out the attached PCA form.

APPLICANT CERTIFICATION

I hereby certify that the above information is true and correct to the best of my knowledge. I understand that supplying false information can disqualify my application and/or subsequent registration.

_____ _____
Signature of Applicant or Responsible Individual (specify which) Date

ALL APPLICANTS MUST HAVE THE REVERSE SIDE COMPLETED BY A PHYSICIAN

PHYSICIANS DISABILITY VERIFICATION (PLEASE PRINT)

NAME OF APPLICANT:_____ SSN:_____

1. Mobility status: ___Ambulatory ____uses cane, walker? ___Non-Ambulatory ___uses wheelchair, scooter?

2. Applicant 's weight: _____ Does combined weight of applicant/wheelchair exceed 600 lbs? ____NO____YES
Length of wheelchair with occupant at longest point _____in. Width of wheelchair at widest point _____in.

3. Nature of disability:_____

4. Is the condition temporary? _____No _____Yes - Expected duration until _____/_____/_____

5. Does the applicant require assistance? _____Yes _____No
(Explain)_____

6. Please answer all section(s) which apply to the applicant.

Verification of Physical Impairment:

Can the applicant climb three 12-inch steps?	_____Yes	_____No
Can the applicant travel 7 blocks on their own using a mobility aid?	_____Yes	_____No
Can the applicant wait outside unaccompanied for 10 mins?	_____Yes	_____No
Can the applicant travel 2 blocks on their own using a mobility aid?	_____Yes	_____No

Verification of Visual Impairment:

Visual acuity with best correction: _____Right _____Left

Visual Fields:_____

Verification of Cognitive Impairment:

Can the applicant give address and telephone numbers upon request?	_____Yes	_____No
Can the applicant recognize landmarks and destinations?	_____Yes	_____No
Can the applicant deal with unexpected changes in routine?	_____Yes	_____No
Can the applicant ask for, understand and follow directions?	_____Yes	_____No
Can the applicant tell time?	_____Yes	_____No

7. What additional conditions prevent the applicant from using ***SCCOOT*** and/or ***Coatesville Link*** regular bus services?

_____

PHYSICIANS DISABILITY CERTIFICATION

The Transportation Management Association of Chester County (TMACC) ACCESS program is provided to persons with disabilities who are functionally unable to use regular *SCCOOT* and/or *Coatesville Link* bus services. Given the nature of this service, the TMACC requires that the physician completing the application provide certification for qualified applicants only. Applications are subject to final TMACC approval.

I hereby certify that the above information is true and correct.

_____ _____ _____
Name of Physician (PLEASE PRINT) Physician's Signature Date

_____
Name of Agency Address Telephone

FOR TMACC USE ONLY

UNCONDITIONALLY ELIGIBLE / CONDITIONALLY ELIGIBLE / INELIGIBLE PCA: Yes / No Svc Animal? Type?

By:_____ Signature _____ Date EXPIRATION DATE: _____