Livonia Community Transit
ADA Certification

The attached application is necessary to determine eligibility for Livonia Community Transit's ADA service. The information obtained specific to this application will be used only by Livonia Community Transit. This information will be kept confidential and will not be provided to any other person or agency.

HOW TO APPLY

1. Please make sure the application is completed in its entirety before submitting. **Failure to complete each section could result in the applicant being denied.** Evaluation of your request cannot begin until the form is completed and received at the Livonia Community Transit office, together with the signed Professional Verification Form. All incomplete applications will be returned for completion.

2. Return completed forms to:

   Livonia Community Transit / City of Livonia
   Civic Park Senior Center
   15218 Farmington Road
   Livonia, MI 48154

   Phone: (734) 466-2700

   Fax: (734) 458-6016

Please call the Transit office at (734) 466-2700 to verify we have received your application

Application for Livonia Community Transit
ADA Certification (Part 1)

The information obtained in this application will be used solely by Livonia Community Transit (LCT) to determine eligibility for ADA Service.

It is important that you answer every question on this application. Evaluation of your request cannot begin until the form is completed and received at the LCT office, together with the signed Professional Verification form. Once the forms have been received, a determination is made within 21 days.

UNREADABLE OR INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.

Name _____
(First) (M) (Last)

Address _____ Apt._____

City _____ State _____ Zip:_____

Home Phone _____ Work Phone _____

Email _____

Date of Birth _____ / _____ / _____ Female _____ Male _____

In Case of Emergency Information:

Emergency Contact Name:_____
(First) (M) (Last)

Telephone Number: ( ) _____

1. What is the nature of your disability?_____

_____

_____

2. Is the disability temporary? ☐ YES ☐ NO

   If YES, expected duration until _____ /_____ /_____

3. Do you travel with a personal care attendant?

   ☐ ALWAYS ☐ SOMETIMES ☐ NEVER

4. Are there any other affects of your disability that we should know about?_____

   _____

   _____

5. Please check the **one** mobility aid that you will most often use when riding LCT.

   ☐ MANUAL WHEELCHAIR ☐ POWERED SCOOTER ☐ ELECTRIC WHEECHAIR

   ☐ LARGE WHEELCHAIR ☐ CANE OR WALKER ☐ SERVICE ANIMAL

Applicant's Signature:

By signing this document, I herby give the City of Livonia, its officers, agents and employees, including but not limited to the Livonia Community Transit, permission to review and consider the medical information set forth below to determine my eligibility to utilize the Livonia Community Transit system. If Livonia Community Transit observes an incident where my safety is in question, they have the right to evaluate my ability to continue riding Livonia Community Transit and /or require an updated ADA certification in order to make a determination of eligibility. I hereby waive my right of privacy, if any, relative to the medical information set forth herein. I certify that the information I gave in this application is true and correct.

Signature of Applicant: _____ Date: _____

Applicant's Representative:

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

Please check one:

- o I certify that the information provided in the application is true and correct, based upon information given me by the applicant.

- o I certify that the information provided in this application is true and correct, based upon my own knowledge of the applicant's health condition or disability.

Name _____
(First) (M) (Last)

Address _____ City_____State ____ Zip _____

Relationship to Applicant _____ Phone Number ( ) _____

Signature _____ Date _____

Application for Livonia Community Transit
ADA Certification (Part 2)

Request for Professional Verification

(To be completed by a licensed professional)

Please carefully review the information provided by the applicant in Part 1 of the above application. Please use the reviewed information to answer the following questions. Your answers should include more than just "Medical Diagnosis". The information provided will allow Livonia Community Transit (LCT) to make an appropriate evaluation of this request and its application to specific trip requests. Subsequent ADA verification may be required in the discretion of LCT in the event of safety concerns or changes in medical conditions. Thank you for your cooperation in this matter.

Name of applicant/patient _____

1. What is your professional relationship to the applicant?
   - ☐ PHYSICIAN
   - ☐ PHYSICAN'S ASSISTANT

2. What is/are the applicant's disabilities? _____

   _____

   _____

3. Is the disability temporary? ☐ YES ☐ NO If YES, expected duration____ /____ /____

4. Please check the **one** mobility aid that the applicant will most often use when riding LCT.

   ☐ MANUAL WHEELCHAIR ☐ POWERED SCOOTER ☐ ELECTRIC WHEECHAIR

   ☐ LARGE WHEELCHAIR ☐ CANE OR WALKER ☐ SERVICE ANIMAL

5. Does applicant need to travel with a personal care attendant? (MUST contain an explanation if either “ALWAYS” OR “SOMETIMES” is checked)

   ☐ ALWAYS **(*If checked, please specify the circumstances)*** _____

   _____

   ☐ SOMETIMES **(*If checked, please specify the circumstances)*** _____

   _____

   ☐ NEVER

6. Please indicate the applicant's level of independence (CHECK ONLY ONE).

   ☐ IS ABLE TO GET TO THE STREET AS LONG AS THERE IS A SIDEWALK

   ☐ CAN GET TO THE STREET ONLY WITH THE HELP OF A PERSONAL CARE ASSISTANT

   ☐ IS UNABLE TO GET TO THE SIDEWALK - REQUIRES DOOR-TO-DOOR SERVICE

7. Is the applicant legally blind? _____YES _____NO

8. Does the applicant have a cognitive disability? _____YES _____NO

9. Does the applicant have any environmental sensitivities? _____YES _____NO

   If yes, please explain: _____

   _____

10. Is the applicant able to:

    Give address and telephone numbers upon request? _____YES _____NO

    Recognize a destination or landmark? _____YES _____NO

    Deal with unexpected change in routine? _____YES _____NO

    Ask for, understand and follow directions? _____YES _____NO

11. Please explain any responses from questions above or describe any other affects of the disability not already provided elsewhere on this form.

_____

_____

_____

_____

Professional Name _____

Title/Position _____

State of Michigan License, Certification or Registration Number _____

Office Address _____

Office Phone _____

Signature of Professional _____ Date _____

Return this form to:
Livonia Community Transit /City of Livonia
15218 Farmington Road
Livonia, MI 48154
Questions? Call (734) 466-2700

FOR OFFICE USE ONLY

Application Rec'd		Expiration
Disability Type		Letter Sent
Personal Care Attendant	Yes	No
Mobility Device		