



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: _____



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
 PHYSICIAN'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 WHEELCHAIR
 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		