

ADA PARATRANSIT APPLICATION

ONLY PERSONS INVOLVED IN DETERMINING ELIGIBILITY WILL USE THE MEDICAL INFORMATION ON THIS FORM.
IT WILL NOT BE SHARED WITH ANY OTHER PERSON OR AGENCY. ALL INFORMATION MUST BE FILLED IN FOR
YOUR APPLICATION TO BE PROCESSED. PLEASE PRINT OR TYPE.

1. NAME KUKATLA RAKESH MR. MRS. MS
LAST FIRST MI

2. STREET ADDRESS 7 ELM ST.

CITY/COUNTY/STATE/ZIP BINGHAMTON, NY 13905 COUNTY.US

MAILING ADDRESS RAKESHBINGK@GMAIL.COM, RANDALL COOK@BROOMEK
3. HOME PHONE _____ OTHER PHONE _____

4. DATE OF BIRTH _____

5. IN CASE OF AN EMERGENCY WHO, LOCALLY, SHOULD BE NOTIFIED? (FAMILY, FRIEND, NEIGHBOR, CASE WORKER)
NAME RANDALL COOK PHONE RANDALL COOK@BROOMEK COUNTY.US
NAME LAURIE WOOD PHONE LAURIE.WOOD@BROOMEK

6. DESCRIBE THE HEALTH CONDITION OR DISABILITY, WHICH PREVENTS YOU FROM USING BC TRANSIT, FIXED ROUTE BUS SERVICE, SOME OF THE TIME OR ALL OF THE TIME.

DISABLED TO USING BIPEDAL EQUIPMENT

IS YOUR CONDITION TEMPORARY? _____ IF SO, HOW LONG? _____
ARE THERE ANY OTHER EFFECTS OF YOUR DISABILITY OF WHICH WE NEED TO BE AWARE?

7. DO YOU USE ANY OF THE FOLLOWING MOBILITY AIDS? CHECK ALL THAT APPLY.

<input type="checkbox"/> MANUAL WHEELCHAIR	<input type="checkbox"/> CRUTCHES	<input type="checkbox"/> CANE
<input type="checkbox"/> ELECTRIC WHEELCHAIR	<input type="checkbox"/> GUIDE DOG	<input type="checkbox"/> BRACES
<input type="checkbox"/> THREE WHEELED SCOOTER/WHEELCHAIR	<input type="checkbox"/> WALKER	<input checked="" type="checkbox"/> OTHER

If you use a wheelchair or a scooter, what are the dimensions (width and length) measured two inches above the ground? Width _____ Length _____

8. DO YOU NEED TO TRAVEL WITH SOMEONE WHO ASSISTS YOU? FOR EXAMPLE, A PERSONAL CARE ATTENDANT? (THE PASSENGER MUST PROVIDE THE PERSONAL CARE ATTENDANT.)

YES NO SOMETIMES

9. PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS, MARKING EITHER “YES”, “NO” OR “SOMETIMES” FOR EACH. IF YOU HAVE MARKED “NO” OR “SOMETIMES”, YOU MUST PROVIDE AN EXPLANATION IN THE SPACE PROVIDED.

A. ARE YOU ABLE TO WAIT FOR A BUS AT A BUS STOP?

YES No SOMETIMES

B. WOULD YOU BE ABLE TO WAIT FOR THE BUS AT A BUS STOP, IF THERE WAS A BENCH OR SHELTER?

YES No SOMETIMES

C. ARE YOU ABLE TO IDENTIFY THE CORRECT BUS?

YES No SOMETIMES

D. ARE YOU ABLE TO GET ON AND GET OFF A FULL SIZE TRANSIT BUS WITHOUT THE ASSISTANCE OF ANOTHER PERSON?

YES No SOMETIMES

E. WOULD YOU BE ABLE TO GET ON AND GET OFF A FULL SIZE BUS, IF IT HAD A MECHANICAL LIFT DEVICE, WITHOUT THE ASSISTANCE OF ANOTHER PERSON? (OTHER THAN THE BUS DRIVER, WHO WILL HELP YOU WITH THE LIFT AND SECUREMENTS SYSTEM IF NECESSARY) PLEASE NOTE THE LIFT HAS HANDRAILS ON BOTH SIDES.

YES No SOMETIMES

F. ARE YOU ABLE TO ASK FOR, UNDERSTAND AND/OR PROCESS INFORMATION, SCHEDULES OR DIRECTIONS THAT ARE NEEDED TO MAKE NECESSARY DECISIONS DURING A TRIP? PLEASE NOTE THAT THE BC TRANSIT DRIVERS, UPON REQUEST, WILL ANNOUNCE MAJOR INTERSECTIONS AND TRANSFER POINTS, AND OTHER STOPS AS REQUESTED.

YES No SOMETIMES

10. ARE YOU LIKELY TO NEED REASONABLE ACCOMMODATIONS ASSOCIATED WITH YOUR TRIP(S)?
Yes No

If yes, what types of accommodations might you need and why?

LIFT FOR BIPEDAL EQUIPMENT

"Note: BC Transit will strive to provide all reasonable accommodations. BC Transit reserves the right to seek alternative solutions to any accommodations that may create a fundamental alteration or undue burden to the system or may create a direct threat to the health or safety of others.

Any accommodation requests should be included in this application or may be scheduled during your reservation process, if possible. All reservations can be made at least one (1) business day in advance and no more than seven (7) days in advance between 8:00am and 4:00pm, Monday through Sunday. Please leave the request as far in advance as necessary, since they will need to be reviewed prior to the scheduled trip, if possible.

11. ARE YOU PREVENTED FROM TRAVELING TO OR FROM A BUS STOP LOCATION, WITHOUT THE ASSISTANCE OF ANOTHER PERSON, FOR ONE OR MORE OF THE FOLLOWING REASONS? (CHECK ALL THAT APPLY.)

- UNABLE (NOT JUST DIFFICULT) TO NEGOTIATE HILLY TERRAIN
 EXTREME SENSITIVITY TO CERTAIN WEATHER CONDITIONS - PLEASE EXPLAIN
- EXTREME FATIGUE CAUSED BY DISEASE, FRAILTY
 UNABLE TO CROSS BUSY INTERSECTIONS
 OTHER REASONS - PLEASE EXPLAIN

12. HAVE YOU EVER HAD TRAINING TO USE THE REGULAR, FIXED ROUTE BUSES?

YES NO IF YES, WHEN? _____

TRAINED BY _____

IF TRAINING WAS COMPLETED, PLEASE LIST THE TRIPS ON WHICH THE APPLICANT IS ABLE TO TRAVEL INDEPENDENTLY.

ORIGIN	DESTINATION	ROUTE NUMBER

13. BEFORE APPLYING FOR THE BC LIFT, WHAT FORM OF TRANSPORTATION DID YOU USE FOR YOUR TRAVEL NEEDS?

CAR

14. PLEASE EXPLAIN IN YOUR OWN WORDS, WHY YOU NEED PARA SERVICE RATHER THAN USING THE FIXED ROUTE SERVICE.

DISABLED TO USE BIPEDAL EQUIPMENT

15. TO HELP US PLAN TRANSIT SERVICE, WE NEED INFORMATION ABOUT YOUR TRAVEL NEEDS. THIS IS FOR PLANNING PURPOSES; YOU MAY TAKE TRIPS FOR ANY PURPOSE YOU WISH. PLEASE TELL US WHAT YOUR EXPECTED TRAVELS NEEDS ARE AND THE ADDRESS OF WHERE THEY ARE LOCATED.

WORK SENIOR CENTER SHOPPING MEDICAL APPOINTMENTS

RECREATION SCHOOL OTHER _____

NAME AND ADDRESS OF DESTINATION BROOME AND OTHER COUNTIES.

NAME AND ADDRESS OF DESTINATION _____

NAME AND ADDRESS OF DESTINATION _____

Part 2 of this Application, the Request for Professional Verification, **MUST BE COMPLETED BY AN APPROPRIATE HEALTH CARE PROFESSIONAL.**

WHO CAN VERIFY: ONE OF THE FOLLOWING HEALTH CARE PROFESSIONALS, AS APPROPRIATE TO YOUR CASE, SHOULD VERIFY YOUR LIMITATIONS:

16. THE FOLLOWING HEALTH CARE PROFESSIONAL IS AUTHORIZED TO PROVIDE INFORMATION TO BROOME COUNTY'S PARATRANSIT ELIGIBILITY REVIEW BOARD. (PLEASE PRINT THE NAME OF THE PROFESSIONAL THAT WILL BE VERIFYING YOUR LIMITATIONS AND CHECK THE TYPE OF HEALTH CARE PROFESSIONAL HE OR SHE IS)

NAME Rakesh Kukatla (SELF)

FOR PHYSICALLY IMPAIRED APPLICANTS AND MENTALLY IMPAIRED APPLICANTS OTHER THAN DEVELOPMENTALLY DISABLED.

- MEDICAL DOCTOR
- PHYSICAL THERAPIST
- CERTIFIED REHABILITATION COUNSELOR

FOR VISUALLY IMPAIRED APPLICANTS:

- OPHTHALMOLOGIST
- OPTOMETRIST
- ORIENTATION AND MOBILITY SPECIALIST CERTIFIED BY NYS COMMISSIONER FOR THE BLIND OR U.S. ASSOCIATES FOR THE EDUCATION AND REHABILITATION OF THE BLIND AND VISUALLY IMPAIRED.

FOR DEVELOPMENTALLY DISABLED APPLICANTS: A QUALIFIED INTELLECTUAL DISABILITIES PROFESSIONAL (QIDP)

- UNABLE TO FIND SPECIALIST OCCUPATIONAL THERAPIST.
- OCCUPATIONAL THERAPIST CERTIFIED BY THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION
 - PHYSICAL THERAPIST CERTIFIED BY THE AMERICAN PHYSICAL THERAPY ASSOCIATION
 - CLINICAL PSYCHOLOGIST WITH A MASTER OR DOCTORAL DEGREE IN PSYCHOLOGY
 - PSYCHIATRIST

I hereby certify that the information given in this application is correct and I authorize the health care professional to whom I submit this application to provide information to the Broome County Paratransit Eligibility Review Board, 413 Old Mill Road, Vestal NY 13850

SIGNATURE OF APPLICANT
Rakesh Kukatla
(SELF)

DATE: 2/20/23

IF SOMEONE OTHER THAN THE APPLICANT COMPLETED THIS FORM ON BEHALF OF THE APPLICANT, THAT PERSON MUST COMPLETE THE FOLLOWING:

PRINT NAME: _____ RELATIONSHIP: _____
TELEPHONE # _____

When Part 1 is completed, TAKE OR MAIL THIS ENTIRE DOCUMENT TO THE HEALTH CARE PROFESSIONAL NAMED ABOVE.

PART 2
PROFESSIONAL VERIFICATION OF ADA
FUNCTIONAL LIMITATION(S) AFFECTING MOBILITY

The applicant is requesting verification of limitation that prevents him/her from using regular BC Transit fixed route buses. The purpose of this form is not to verify the applicant's medical condition, but to verify the effect of the medical condition on his or her ability to get around on his or her own. The application for paratransit service is not only used to determine IF an applicant needs paratransit service, but also WHEN AND UNDER WHAT CONDITIONS the applicant needs paratransit services. **All questions must be answered for this form to be considered complete.**

The information will allow Broome County's Paratransit Eligibility Review Board to make an evaluation of this person's request for transportation on BC Lift. BC Lift is Broome County's paratransit service, which is for use only by those who are unable to use the BC Transit fixed route service.

THIS VERIFICATION OF LIMITATIONS ON MOBILITY RELATES TO BROOME COUNTY'S COMPLIANCE WITH FEDERAL LAW. AN INFORMATION SHEET SUMMARIZING THIS LAW, THE AMERICANS WITH DISABILITIES ACT (ADA), IS INCLUDED FOR YOUR REVIEW. PLEASE NOTE THAT BC TRANSIT NOW HAS SUBSTANTIAL ACCESSIBLE SERVICE. ALL BC TRANSIT BUSES ARE EQUIPPED WITH LIFT DEVICES, WHICH ARE AVAILABLE FOR USE BY ANY INDIVIDUAL WITH A MOBILITY LIMITATION THAT PREVENTS STAIR CLIMBING. BC TRANSIT IS REQUIRED TO MAKE INFORMATION AVAILABLE IN ACCESSIBLE FORMATS FOR THE VISUALLY OR HEARING IMPAIRED.

1. Capacity in which you know the applicant: RAKESH KUKATLA
(Name of applicant)
SELF

How does the applicant's condition/disability cause functional limitation(s) that affects this person's ability to get around? If the person's ability to get around on their own varies in degree at different times, please explain, giving specifics.

DISABLED TO USING BIPEDAL EQUIPMENT

2. Is the condition? Permanent _____ Temporary Expected Duration _____

3. If the applicant has a disability affecting mobility, answer the following:

A. Does the applicant use any mobility aids? (Examples are wheelchairs, scooter, crutches, canes, guide dog, walker and/or braces) if yes, please list and specify under what conditions:

BIPEDAL EQUIPMENT

B. With the use a mobility aid(s), estimate how far he/she can travel independently?

AS FAR AS BC LIFT TAKES THE BIPEDAL EQUIPMENT

C. Can the applicant climb steps without assistance? Y

D. How long can this person wait for a bus at a bus stop? BC UPT. PICKUP

FROM HOME

E. Is the individual able to independently maneuver on to and off a mechanical lift device on the bus, with or without a mobility aid? Yes No. The lift can accommodate three and four wheeled carts no larger than 30" x 48" measured two inches above the ground. The weight of occupied wheelchair cannot exceed 600 pounds. The lifts are equipped with handrails and they accommodate standees with or without walkers, crutches or canes.

F. Does this person require a personal care attendant (PCA) when traveling on public transportation? Yes No

G. Is the applicant able to read information signs? Yes No

If not, please explain: _____

H. Is the applicant able to give their own address and phone number? Yes No

I. Is the applicant able to recognize landmarks? Yes No

J. Are they able to deal with unexpected situations or changes? Yes No

K. Is the applicant able to ask for, understand and follow directions? Yes No

4. What, if any, specific weather conditions prevent this applicant from getting around on his or her own? Please be specific.

BC LIFT

5. Please describe any other functional limitation(s) affecting mobility not described above. Please be specific.

BC LIFT

Signature: Rakesh Kukatla

Your name and title: RAKESH KUKATLA, OWNER

OWNER

Office address: 7 ELM ST. BING. NY 13905

OWNER EMAIL RAKESH.BING@GMAIL.COM,

Office phone number: _____ Fax Number: _____ Date: _____

HOMESEC.BING@GMAIL.COM,

Return completed form to: BC Transit, 413 Old Mill Rd., Vestal, New York 13850

If you have questions, please call (607) 763-4464
Thank you for your assistance.