# Cross County Connection

Transportation for Orangeburg and Calhoun Counties

Thank you for your interest in the Cross County Connection Paratransit Transportation Service. This special transportation service is available to qualifying persons with permanent or temporary disabilities that prevent them from using the regular fixed route bus service in Orangeburg County.

Please complete your application as thoroughly as possible. The questions will assist us in determining the specific limitations you have in using our service.

Remember, in order to be able to receive the service after your application has been processed and you are certified eligible, you must reside within 3/4 of a mile of our fixed route corridor and the time of your trip must fall within the hours of the fixed route bus route. If you do not reside within the 3/4 radius, then you must have a means of getting within our service area before transportation is provided.

It will be necessary for a licensed medical professional (not a relative or friend) that sees you on a professional basis to complete the Medical verification portion of your application. This person may be a registered nurse, social worker, physician, physical therapist, psychologist, occupational therapist, chiropractor, speech pathologist, physician's assistant, or mental health counselor employed by a medical facility. Contact our office if assistance is needed in completing your application. Incomplete applications will be returned and not considered until all information (including the medical verification portion) is received. ***Faxed copies will not be accepted.***

Your eligibility determination will be made 21 days within receipt of this completed application. You will be notified by letter and, if applicable, your paratransit identification card will be inside. If you are denied eligibility, you may appeal the decision and the appeals process will be mailed to you with your decision letter.

**Send your completed application to:**

**Cross County Connection**
**ADA Paratransit Office**
**1630 Carolina Avenue**
**Orangeburg, SC 29115**
**(803) 531-1302**

## REQUEST FOR CERTIFICATION OF ADA PARATRANSIT ELIGIBILITY

**This portion is to be filled out by applicant - Please print.**

The information obtained in this certification process will only be used by Cross County Connection for the provision of ADA paratransit transportation services in Orangeburg County. Information will only be shared with other transit providers to facilitate travel in those areas. The information will not be provided to any other agency.

1. Name_____

2. Address_____

   _____

   City _____ State _____Zip_____

3. Telephone Number (Home)_____ (Work)_____

   **In Case of Emergency Contact**

   **Name_____Relationship_____**

   **Contact Number_____**

4. What do you claim is the disability which prevents you from using our fixed route service?_____

   _____

   Is this condition temporary? No____ Yes____
   If yes, how long? _____

5. **How does your disability affect your ability to ride the regular fixed route bus service? Be specific.**

   Are there any other physical or mental disabilities that impact your **FUNCTIONAL ABILITY** to ride the regular fixed route bus service? _____Yes _____NO
   If you answered yes, please explain

6. Have you ever used a public transit bus in the past? ___☐___Yes ___☐__No

   a. How often? ☐_Daily ☐_Weekly☐_Montly☐_Occasionally
   b. When did you stop?_____
   c. Why did you stop traveling by public transit bus?_____

7. Indicate which support devices(s) when traveling or walking outside your home.

   I do not require a support device.___☐____ Respirator/Oxygen Tank ____☐____

   Manual Wheelchair___☐____ Motorized Wheelchair___☐____Walker___☐____

   Support Cane ___☐___ Crutches___☐___ Other (explain) _____

   Service Animal ____☐____ What type of animal is used? _____

   What function does the animal provide?_____

   _ _

8. Do you currently travel with a Personal Care Attendant (PCA), a person who assist you regularly with boarding and exiting the vehicle when you travel? ☐_Yes☐_No

   What type of assistance does your PCA provide related to transportation_____

   _ __

   Name(s) of Personal Care Attendant (PCA)

   _____

   _____

9. Please answer the following questions:

   Can you travel 200 feet without the assistance of another person?
   Yes☐ No☐ Sometimes Describe_____

   Can you climb three 12-inch steps without assistance?
   Yes☐ No☐ Sometimes Describe:_____

   Can you wait outside without support for 15 minutes?
   Yes☐ No☐ Sometimes Describe:_____

I have reviewed all the information contained in this application. I certify that all the information is true and correct to the best of my knowledge and ability. I understand that falsification of information may result in denial of service. I understand that only the information required to provide paratransit services will be disclosed to those who perform those services. I understand that if any portion of this application changes, including mobility devices, I will notify the Cross County Connection ADA paratransit office immediately. I understand that the Cross County Connection may contact the licensed medical professional who has completed the Professional Verification Form attached to this application in order to confirm or clarify this information.

**Release of Information**

The following Health Professional_____ is familiar with my disability and is authorized to provide the information to the Cross County Connection ADA paratransit service required to complete this certification.

Name_____

Address_____

City _____State _____ Zip_____

Phone Number_____

Signed_____
(Applicant's signature)

Date____/____/____

11. If a person other than the applicant has completed this form, please check one:

_____ I certify that the information provided in this application is true and correct based upon the information given to me by the applicant.

_____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_____Address_____

City _____ State _____ Zip_____

Daytime Phone_____ Relationship_____

Signed_____ Date____/____/_____

**REQUEST FOR PROFESSIONAL VERIFICATION**

**This section is to be completed by a Physician or Healthcare Professional - Please type or print.**

The applicant has signed a Release of Information on the previous page and would like to thank you for your assistance with this application. He/she is applying for ADA paratransit transportation services and the following information is needed in order to assist with a qualifying disability determination which is required in order to use the transportation system.

What is the medical diagnosis of the applicant's disability? _____

_____

Please describe the condition (whether physical or cognitive) which functionally prevents the applicant from using regular fixed route bus service. Be as specific as possible in your description.

_____

_____

Is the condition temporary? No____ Yes____ Expected duration:_____

If the person has a disability affecting mobility, is this person:

Able to walk 200 feet without assistance? Yes____ No____

Able to climb three 12-inch steps without assistance? Yes____ No____

Able to wait outside without support for 15 minutes? Yes____ No____

Does this person use mobility aids? If so, what kind?

_____

Is the applicant visually impaired? Explain._____

Is there a cognitive impairment? No_____ Yes_____ If yes, can this applicant:

Give addresses and telephone numbers upon request? Yes____ No____

Recognize a destination or landmark? Yes____ No____

Ask for, understand, and follow directions? Yes____ No____

**Does this person require a personal care attendant/escort to help with their mobility?**

**Yes____ No____**

Your Name:_____ Office Address:_____

(Print or type)

_____ Office Phone Number_____

Signature:_____

(Physician or Healthcare Professional Signature)

**Note: This application must be signed by an healthcare professional. Stamped signatures not accepted.**

**********

OFFICE USE ONLY

DAR Eligible? _____ Card#_____ Effective Date_____

Decision Letter mailed _____ Personal Care Attendant/Escort

Approved_____

Staff Member _____ Date _____

**********