Rider's Name:

Phone No:

Caller Box 10007

Saipan, MP 96950

Telephone: 670-664-2682

Fax: 670-664-2692

Email: cnmicota@gmail.com

COTA use only

Received by:

Date Received:

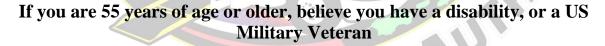
Approved Disapproved

Date
Initials

Commonwealth Office of Transit Authority

Application for Eligibility of ADA Paratransit Services

March 2018



... that prevents you from using regular transportation, please complete this application and return to the address above to determine your eligibility to receive

ADA Paratransit services

The Federal Americans with Disabilities Act (ADA) requires comparable public transportation services for person with disabilities who are unable, because of their disability to use a regular transportation.

If you believe you have a disability that prevents you from using the regular public transportation, please complete this application and return it to the address below to determine your eligibility.

It is important that all parts of this application are completed. You, the applicant, are responsible for the completing the entire application form.

- COTA will review your application and follow-up as necessary to determine you eligibility for paratransit series.
- COTA will notify you within 15 days of receiving your completed application regarding your eligibility for paratransit services.

If you have not received a determination after 15 days of submitting your application, please call (670) 664-2682. If you are denied eligibility, you have a right to appeal the eligibility decision. Please contact COTA on the appeals process.

PLEASE SEND COMPLETED APPLICATIONS TO: COTA, Caller Box 10007. Saipan, MP 96950.

If you have questions regarding the eligibility application process, ADA Paratransit Service, or other transit matter, please call (670) 664 – 2682, fax 670-664-2692, send email to cnmicota@cota.gov.mp or visit our website at http://www.cota.gov.mp.

Commonwealth Office of Transit Authority

Application of ADA Paratransit Service Eligibility

First Time Applying	Re	newal		Re-Applying
SECTION 1 : Perso	onal Information			
Check 1: Mr.	☐Mrs.	☐Miss.	Other_	(Dr./Rev.,etc)
Name:				
Last	Fi	rst	Middle Initial	
Mailing Address				
	Address	City	State	Zip Code
Residence Address: _				
5	Village	Street	House	/Apt.#
Date of Birth:	(mm/dd/yy)			
Phone: (H):Email Address:	(W	7):	(Cell)	7,6
Emergency Contact:			1011	
Name:	Relationsh	nip:	Contac	t Number:
Please describe regular transpo			ail how it prevents	you from using
2. My condition is	s: Permanen	t \text{Long}	-Term Tempo	rary
3. Are there any o	ther conditions that	at limit your abi	llity to use the COT	(Expected duration) (EA Van? Yes or No.

□ Use	es Cane	e check all that apply) Uses Walker Uses Crut t instead of steps Requires Portab	
Whee		Manual ☐ Motorized ☐ Multi- bility aid or on your own, how many 1 block = 500 feet)? Number of Block	
2.	Do you re travel?	equire a Personal Care Attendant (PCAYes \(\sumsymbol{No} \sumsymbol{\subsymbol{No}} \subsymbol{\subsymbol{O}}	A) or escort to accompany you when you
3.	If you che	ecked YES, please list the name(s) of	your PCA (agency or escort):
	Name:	Address:	Telephone:
	Name:	Address:	Telephone:
	Name:	Address:	Telephone:
4.	Does you Yes□		o or from your house to your driveway? splain: (MUST COMPLETE)
5.	Can you	climb three (3) steps without assistance	e?□Yes □ No If NO , please explain:
6.	Is your ab	sility to travel or to wait outdoor affects □ No If YES , please describe con	ted by extreme hot or cold weather

7.	Are you ab	Are you able to board or disembark from a COTA vehicle with a wheelchair lift?					
	Yes□	No □	If NO , please explain:				
8.	Are you ab Yes□	le to get around No □	independently without assis If NO , please explain:	tance?			
			A Thin				
9.	Are you ab Yes□	le to ask for, und	derstand and follow direction If NO , please explain:	ns?			
				-			
[professiona	al to verify the in		ecessary to contact a healthcare ovided. Your signature on the			
	worker, or		d or registered specialist) de	nsed physician, therapist, social esignated by the applicant, who			
	Name of H	ealth Care Profe	ssional:				
	Office/Mai	ling Address:					
	City	State _	Zip Code	Telephone			
	I hereby ce release of i (COTA). I Section 3 o	rtify that the info nformation and p also authorize C of this section to n about my disab	ormation provided in this ap photos to the Commonwealt OTA to contact the health c	plication is correct. I authorize the h Office of Transit Authority are professional who completed ng my disability to COTA. The			
	Print, Sign,	, and Date:					

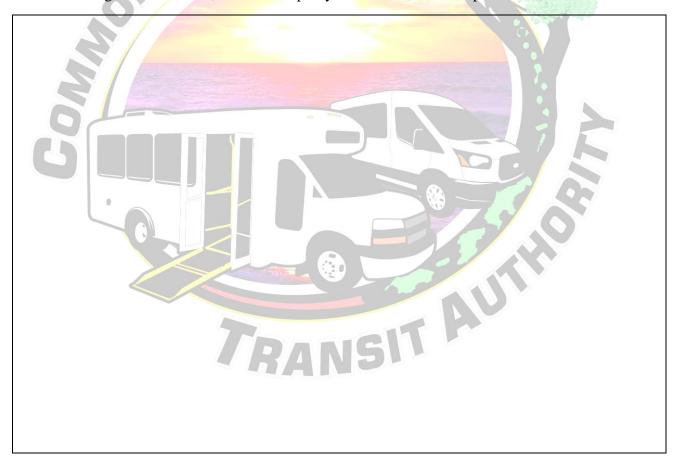
Signature: __

(mm/dd/yyy)

If you are not the applicant but have completed this application on the applicant's behalf, you must provide the following information:

Full name (Print):	Telephone:			
Mailing Address:	City:	State	Zip Code:	
Relationship to Applicant:	- Administration of the Control of t	2000 M		
I hereby verify that to the best of a be verified by the applicant's heal		A CONTRACT OF THE PARTY OF THE	ven above is correct and ca	ın

Please give directions and draw a map to your residence in this space.



If you are 55 years old or older please stop here and submit the completed application to COTA

FOR United States MILITARY VETERANS

Please provide a copy of a valid DD FORM 214 for proof of veteran status and another valid ID.

You have now completed the applicant section of the ADA Paratransit Eligibility Form. Please give this entire Application to the Health Care Professional most familiar with your abilities and disabilities

Section 3: Health care – Professional Verification

VERIFICATION OF PARATRANSIT ELIGIBILITY

Health Care Professional Verification of Applicant's Disability and Functional Capabilities This portion of the application form is to be completed by a Health Care Professional, who is familiar with the applicant's abilities and disabilities, as they relate to their abilities to travel about the community.

The attached applicant has applied for ADA Paratransit Service with the Commonwealth Office of Transportation Authority (COTA). You are being asked to provide information regarding this applicant's disability as it affects their ability to use the regular transportation to move about the community. Please note that all of our vans are lift-equipped for individuals who use wheelchairs, scooters or unable to use the steps. COTA provided the paratransit (Curb-to-Curb) service to people who cannot use regular transportation. Not all persons with disabilities qualify for paratransit services.

Please assist our office in determining the eligibility state of	
By reviewing the enclosed application and completing the attached	d verification of paratransit
eligibility form. If you have any questions regarding ADA Paratra	nsit eligibility, please contact
the COTA at (670-664-2682).	
I have reviewed the enclosed application and I Agree/Disagree with	th the information provided. If
you circled disagree, please explain why:	
The applicant is unable to use the regular transportation because:	
Temporary: Expected duration until	(mm/dd/yyyy)
Long Term: Conditions with potential for improvement or	long periods of remission
Permanent: Condition with no expectation of improvement	t.
I hereby certify that the above information is true. False verifi	cation may result in the
disqualification of the applicant	

Full name (Print&Sign):_______ Telephone: _____