

**PART TWO: C-Tran Specialized Door-to-Door Services**  
**Application & Authorization to Release Information Regarding Eligibility for C-Tran**

Page 1: To be completed by **Applicant or Legal Guardian ONLY**. Please print clearly.

*I hereby authorize the professional listed in Section Two below to provide information to C-Tran regarding my ability to use C-Tran fixed route bus service. I understand that all information will be kept confidential and be used only for transit-related purposes.*

**Section One:**

**Applicant's signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Print Name** \_\_\_\_\_

**Street address** \_\_\_\_\_

**Mailing address** \_\_\_\_\_ **E-mail address** \_\_\_\_\_

**City** \_\_\_\_\_ **Zip code** \_\_\_\_\_

**Telephone: Home** \_\_\_\_\_ **Work** \_\_\_\_\_

Accessible format materials required? Braille Large print Audio cassette

*The professional identified below must be one of the following currently licensed professionals: registered nurse, physician, clinical social worker, psychologist, physical therapist, occupational therapist, speech pathologist, vocational rehabilitation specialist, or recreation therapist.*

**Section Two:**

**Name of professional** \_\_\_\_\_

**Clinic or agency** \_\_\_\_\_

**Street address** \_\_\_\_\_

**City** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Telephone** \_\_\_\_\_

If this application has been completed by someone other than the applicant:

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Print name** \_\_\_\_\_

**Street address** \_\_\_\_\_

**City** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Telephone: Home** \_\_\_\_\_ **Work** \_\_\_\_\_

**Relationship to applicant** \_\_\_\_\_

**Return completed form to:**

**Town of Cary Planning Dept., Attn: A. Tenorio, Cary Transit, PO Box 8005,  
Cary, NC 27512**

Or **fax** to (919) 380-6426

Date mailed: \_\_\_\_\_



## Professional Verification Questionnaire Regarding Eligibility for C-Tran

This questionnaire must be completed by one of the following **currently licensed professionals**: registered nurse, physician, psychiatrist, clinical social worker, psychologist, physical therapist, occupational therapist, speech pathologist, vocational rehabilitation specialist, or recreation therapist.

The Americans with Disabilities Act of 1990 (ADA) is a civil rights bill which bans discrimination against people with disabilities. To meet their needs, C-Tran provides both fixed route bus service (buses which operate over fixed streets on fixed schedules with lifts) and C-Tran door-to-door service (vans which go door to door upon request). C-Tran has limited resources with which to provide service to the community, so making an accurate determination of eligibility is crucial.

Name of applicant (print): \_\_\_\_\_ has applied for certification to use C-Tran's Door-to-door service, and has given you the authority to provide information that will allow C-Tran to make an accurate determination of the need for C-Tran door-to-door service. Please answer all questions as accurately as possible so those individuals who are truly in need of this special transit service will have access to it. All information will be kept confidential and be used only for transit-related purposes.

If you have questions about how to complete this form, call 481-2020. Your quick response is greatly appreciated by C-Tran and by the applicant. Thank you.

**1. Which of these mobility aids or equipment does the applicant use to get around?**  
(check all that apply)

- |                                      |   |   |
|--------------------------------------|---|---|
| <input type="checkbox"/> None        | <input type="checkbox"/> Manual wheelchair    | <input type="checkbox"/> Service animal |
| <input type="checkbox"/> Cane        | <input type="checkbox"/> Powered wheelchair   | <input type="checkbox"/> Picture board  |
| <input type="checkbox"/> Crutches    | <input type="checkbox"/> Powered scooter/cart | <input type="checkbox"/> Alphabet board |
| <input type="checkbox"/> Walker      | <input type="checkbox"/> Leg braces           |   |
| <input type="checkbox"/> White cane  | <input type="checkbox"/> Portable oxygen      |   |
| <input type="checkbox"/> Other _____ |   |   |

**2. Does applicant normally travel with a personal care attendant (PCA)?** *A personal care attendant is someone designated or employed specifically to assist the applicant with the completion of at least one daily activity on a regular basis, such as mobility assistance, personal care, eating, or communication.*

- Always  
 Sometimes--Please explain \_\_\_\_\_  
 No

**3. Could the applicant pay the fare without assistance?** *C-Tran buses are equipped with fare boxes immediately inside the front door of the bus, next to the driver. Fares may be paid with coins, punch tickets, and passes.*

- Yes  
 Yes, if someone could purchase tickets or passes for the applicant  
 Yes, with training  
 No--Please explain \_\_\_\_\_

~turn over to complete questionnaire~

**4. Could the applicant ride on a C-Tran bus for 20 to 25 minutes?** *The typical ride time on a C-Tran bus is 20 to 25 minutes. The buses are equipped with forward and side facing seats. There are passenger assists located along the top of each seat, overhead at 70" above the floor along both sides of the aisle, and vertically from ceiling to floor at several locations.*

- Yes
- Yes, except under these circumstances--Please explain \_\_\_\_\_
- No--Please explain \_\_\_\_\_

**5. Could the applicant communicate with the bus driver and/or other passengers?** *It is sometimes necessary during the course of a bus trip to communicate with the bus driver and/or other passengers.*

- Yes
- No--Please explain \_\_\_\_\_

**6. What is the applicant's physical or cognitive disability?**

\_\_\_\_\_

**7. Is this disability temporary?**

- Yes--How long do you expect it to last? \_\_\_\_\_ months
- No
- I don't know--Please explain \_\_\_\_\_

**8. Does this disability change from time to time in ways which affect the applicant's ability to get around?**

- Yes--Please explain \_\_\_\_\_
- No

|   |                   |
|---|-------------------|
| <b>9. Signature of Medical Provider</b> _____ | <b>Date</b> _____ |
|---|-------------------|

Printed name \_\_\_\_\_

Clinic or agency name \_\_\_\_\_

Street address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_

License, certification, or registration number \_\_\_\_\_

Capacity in which you know the applicant \_\_\_\_\_

**Return completed forms to:**  
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Or **fax** to (919) 380-6426

*C-Tran is a service operated by First Transit, Inc. and provided by the Town of Cary, PO Box 8005, Cary, NC 27512. Contact: Ana V. Tenorio, Cary Transit, Town of Cary Planning Department, Phone: (919) 469-4086, Fax (919) 380-6426, Email: ana.tenorio@townofcary.org, and/or www.townofcary.org for more information.*