St. Mary's Transit System (STS)
ADA-SSTAP Service, Disability and Senior Discount Cards

APPLICATION INSTRUCTONS

This Application is intended to assist in the mobility and independence of persons with disabilities and seniors who have transportation needs. There are three (3) basic assistance programs offered as a part of this Application. Please check one of the boxes below to indicate which program you are applying for to facilitate our review of your request. All forms required below must be completed and accurate.

☐ **Would you like to apply for Paratransit Transportation?**

Paratransit

If you have a disability that prevents you from utilizing the public STS fixed transit services and you need Door-to-Door service, please check this box and **fill out Sections 1-6 (Only complete Section 6 if qualifying by a physician).**

Once approved by our office, paratransit transportation services will be provided through the Transit System's ADA or SSTAP programs.

☐ **Would you like to apply for a Disability Discount Fare Card?**

Disability Discount

If you have a disability that does not prevent you from utilizing the public STS fixed transit services, please check this box and **fill out Sections 1, 2, 5 (optional), and 6 (only complete Section 6 if qualifying by a physician).**

A Disability Discount Fare Card will entitle the card bearer to a discounted fare for transportation. These discounts will only be available after you obtain approval from our office.

☐ **Would you like to apply for a Senior Discount Fare Card?**

Senior Discount

If you are age 60 and above and utilize the public STS fixed transit routes, and you are interested in receiving discounted fares, please check this box and **fill out Sections 1 and 5 (Section 5 is optional)** of the Application Form.

To obtain a Senior Discount Card proof of age (i.e. identification card, birth certificate, etc.) will be required.

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APPLICATION FORM
(Please provide all of the requested information)

Paratransit 

Disability Discount 

Senior Discount 

Section 1
GENERAL INFORMATON

First Name (please print):_____

Last Name (please print):_____

Date of Birth (only required for Senior Discount Fare Cards):
Month _____ Day _____ Year _____

Street Address_____ Apt #_____

City_____ State_____ Zip Code _____

County_____

Directions to your home: _____

_____

_____

Phone # (Daytime): _____ (Evening): _____

Cell Phone # (Optional): _____

Mailing Address (if different than your street address shown above):

_____

City_____ State_____ Zip Code _____

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APPLICATION FORM
(Please provide all of the requested information)

Paratransit

Disability Discount

Section 2:
CERTIFICATON

This Section to be completed **ONLY** if you are applying for **Paratransit Transportation or a Discount Disability Fare Card**. Eligibility will be based on one of the following:

- Certified by a doctor or psychiatrist; or
- Given through Social Security (SSI or SSDI); or
- Disabled through the Veteran's Administration; or
- Temporary Disability Assistance Program (TDAP) formally called TEMHA; or
- Declared disabled by a different entity? Please explain below; or
- Section 6 of this application packet completed by a physician

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Disability Duration (Please check one):

☐ Permanent ☐ Temporary Until_____ or ☐ Unknown at this time

Paratransit Transportation requests please proceed to **Section 3** of this packet. Missing or inaccurate information may cause a delay in response and approval of services.

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Paratransit

Section 3:
Transportation
(Please provide all of the requested information)

This Section **must** be completed if you are applying for **Paratransit Transportation** services. Answering the questions completely will help us provide the service that you need.

Please list the Mobility Aids / Equipment that you use (check all that apply):

☐ N/A
☐ Manual Wheelchair ☐ Electric Wheelchair ☐ Cane/Walker
☐ Powered Scooter ☐ Hearing Aid ☐ Oxygen
☐ Service Animal ☐ Crutches
☐ Other _____

Platform lifts capacity – 600lbs with passenger – and will fit on the platform measuring 48.5" long by 31" wide. Platform lifts may be used for wheel chairs, walkers, crutches or those who have difficulty climbing entry steps.

Please also take the time to complete the following (check all that apply):

1. Can you travel from your home to the curb or end of your driveway (say 200 feet) without assistance of another person? ☐Yes ☐No

2. Can you travel ¼ mile without assistance from another person? ☐Yes ☐No

3. Can you climb three 12 inch steps without assistance? ☐Yes ☐No

4. Can you wait outside without support for 10 minutes? ☐Yes ☐No

5. Do you require a personal care attendant to travel with you? ☐Yes ☐No

Would you be interested in the Travel Training program? The program provides information on how to use STS buses and routes. ☐Yes ☐No

If you mark 'Yes', a member of our STS staff will contact you for additional information.

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Paratransit 

Disability Discount 

Senior Discount 

Section 4:

Applicant/Representative Certification

(Please provide all of the requested information)

I certify that the preceding information is true and correct. I authorize St. Mary's Transit to use the information provided to arrange transportation services, including sharing my information with drivers, as necessary.

Applicant Signature _____ Date _____

If this application was completed by someone other than the individual requesting paratransit transportation or a discount fare card, please complete the following information:

Name_____

Relationship to Applicant_____

Street Address_____

City_____ State_____ Zip_____

Phone Number (Daytime) _____ (Evening) _____

Reason applicant was unable to complete form _____

Signature: _____ Date_____

Paratransit 

Section 5 (Optional)
SUPPLEMENTAL INFORMATON

Disability Discount 

Senior Discount 

Note: The following information will only be in case of emergency. Completion of this Section is optional for all applicants.

Are there any other effects of your disability that we should know about when providing you with transportation services (i.e. seizures, heart condition, allergies, etc)?

Please provide the name and number of a friend or relative to contact in case of an emergency (Optional):

Name _____ Relationship _____

Phone (Daytime) _____ (Evening) _____

Address _____Apt._____

City_____ State_____ Zip_____ County_____

St. Mary's Transit System (STS)
ADA-SSTAP Service, Disability and Senior Discount Cards

Paratransit

Disability Discount

Section 6 (Only complete if qualifying by a physician)
Request for Professional Verification

Dear Health Care Professional:

You are being asked by _____ (applicant) to provide information regarding his/her ability to use our transit services. Federal law requires that STS provide paratransit service to persons who cannot use fixed-route transit services. The information you provide will allow us to determine the applicant's eligibility for service.

To qualify for STS Paratransit service, a person must be unable to use regular public transit due to physical or mental disability. Individuals qualify if

1. as the result of their disability, he/she cannot board, ride, or disembark from a STS bus;
2. he/she has a specific impairment-related condition which prevents him/her from getting to or from bus stop.

PLEASE NOTE: This does not include persons who find it uncomfortable or difficult to get to and from bus stops nor does a disability qualify a person for ADA service.

Resources for this program are limited and your evaluation of each person must be based solely upon the individual's ability to use regular transit. Your verification should consider only the presence of a disabling condition, not the applicant's age or economic status. Please exercise care in evaluating applicants for this program. False verification could result in travel limitation for persons legitimately qualified to use the program.

Capacity in which you know the applicant: _____

Describe in detail each disability and explain how it prevents the applicant from using public transit.

Disability	How it prevents them from using public transit

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Section 6
Request for Professional Verification cont.

Are there other effects of the applicant's disability which we need to be aware of?

Obesity/weight ☐ seizures ☐ shortness of breath ☐
Memory Problems ☐ Paralysis ☐ dizziness ☐
Other ☐ _____
If you checked obesity, please indicate the applicants Ht._____ and Wt._____

Are the applicant's disabilities:

Permanent ☐ Temporary ☐ until_____
Unknown ☐

Is this applicant's disability affected by the weather? If so, please explain how_____
_____

The Applicant can:	Fully	With Some Difficulty	With Extreme Difficulty	Not at all
☐Walk without assistance				
Walk200 feet (1 Block) without assistance	☐	☐	☐	☐
Walk 400 feet (2 Blocks) without assistance	☐	☐	☐	☐
Walk 600 feet (3 Blocks) without assistance	☐	☐	☐	☐
Walk 1320 feet (1/4mile) without assistance	☐	☐	☐	☐
Walk 2640 feet (1/2 mile) without assistance	☐	☐	☐	☐
Walk 2960 feet (3/4 mile) without assistance	☐	☐	☐	☐

The Applicant can:	Fully	With Some Difficulty	With Extreme Difficulty	Not at all
☐Travel with a mobility aid				
Travel with a mobility aid (cane, walker, wheelchair)	☐	☐	☐	☐
Travel 200 feet (1 Block) with a mobility aid	☐	☐	☐	☐
Travel 400 feet (2 Blocks) with a mobility aid	☐	☐	☐	☐
Travel 600 feet (3 Blocks) with a mobility aid	☐	☐	☐	☐
Travel 1320 feet (1/4mile) with a mobility aid	☐	☐	☐	☐

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Section 6
Request for Professional Verification cont.

All Applicants:	Fully	With Some Difficulty	With Extreme Difficulty	Not at all
Board or disembark a STS Bus independently	☐	☐	☐	☐
Recognize vehicle markings without assistance	☐	☐	☐	☐
Wait at a location without shelters and/or benches	☐	☐	☐	☐
Plan trip and interpret schedules independently	☐	☐	☐	☐
Plan trip and interpret schedules with assistance	☐	☐	☐	☐

Professional's Name: _____

Occupation/Title: _____

Organization: _____

Office #:_____ Fax #: _____

Street Address: _____

City: _____ State: _____ Zip: _____

I hereby certify that the above information provided regarding the applicant is true. STS will make the final determination on an applicant's eligibility for STS Paratransit service.

Physician's Signature: _____ Date: _____

Return application to

Please ensure the application is completed and signed.

Mail to: St. Mary's County Government
St. Mary's Transit System
P.O. Box 409
California, MD 20619

Fax to: 301-866-6797

Contact Information

For Questions/Concerns: 301-863-8400 ext. 1120

For Office Use Only

Approval
☐ Approved ☐ Denied

Program
☐ ADA ☐ SSTAP
☐ Disability Discount Fare Card
☐ Senior Discount Fare Card

Disability Duration
☐ Permanent
☐ Recertification Required

Notes:

Date Received:
Received by:

Approval Date:
Approved by:

Renewal Date:

☐ Entered in Computer (Access and CTS)
Employee Initials _____ Date _____