Riders Full Name: _____

Phone No.: _____

For COTA's Official Use ONLY		
Received By:		
Date Received:		
	☐ Approved	☐ Disapproved
Date:		
Print & Sign:		

Address:
12841, Lower Base Dr., Saipan
Caller Box 10007
Saipan MP, 96950
Telephone No.: (670) 664-2682
Email: cnmicallaride@gmail.com
Website: transit.cnmi.gov

Commonwealth Office of Transit Authority (COTA)

Application for Eligibility of ADA Paratransit Services

July 2024

If you are 55 years of age or older, believe you have a disability, or a U.S. Military Veteran

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

ADA Paratransit Services

The Federal Transit Americans with Disabilities Act (ADA) requires comparable public transportation services for persons 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 is completed. **You, the applicant, are responsible for completing the entire application form.**

- COTA will review your application and follow-up as necessary to determine your eligibility for paratransit services.
- 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 contract the Commonwealth Office of Transit Authority (COTA) for more information on the appeal process.

Please send completed applications to:

Commonwealth Office of Transit Authority (COTA)

Caller Box 10007, Saipan MP, 96950

OR

Via personal delivery to:

Commonwealth Office of Transit Authority's Administrative Building and Maintenance Facility located in Lower Base Dr., Saipan, Building No. 12841

If you have any questions regarding the eligibility application process, ADA Paratransit Service, or other transit matter, please call COTA's One-Call/One-Click Transportation Information Resource Center at (670) 236.2682 or email to cnmicallaride@gmail.com or visit our website at transit.cnmi.gov.

Commonwealth Office of Transit Authority

Application of ADA Paratransit Service Eligibility

☐ First Time Applying ☐ Renewal ☐ Re-Applying

SECTION 1: Personal Information

Check 1: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Other_____(Dr./Rev., etc.)

Name: _____ _____ _____
Last Name First Name M.I.

Mailing Address: _____ _____ _____ _____
Address City State Zip Code

Residence Address: _____ _____ _____
Village Street House/Apt.#

Date of Birth: _____
(mm/dd/yy)

Home Phone: _____ Work Phone: _____ Cellphone: _____

Email Address: _____

Emergency Contact:

Name: _____ Relationship: _____ Contact No.: _____

1. Please describe your disability and explain in detail how it prevents you from using regular transportation:
   _____
   _____
   _____
2. My condition is: ☐ Permanent ☐ Long-Term ☐ Temporary _____
   (Expected Duration)
3. Are there any other conditions that limit your ability to use the COTA Van? (Yes or No). If yes, please explain:
   _____
   _____
   _____

SECTION 2: Mobility Information

Mobility: (Please check all apply)

☐ Cane ☐ Walker ☐ Crutches ☐ Use Animal Services

☐ Need Lift instead of steps ☐ Require Portable Oxygen ☐ Other _____

Wheelchair: ☐ Manual ☐ Motorized ☐ Multi-Whell Scooter Length/ Width: _____

1.Using mobility aid or n your own, how many blocks can you walk on level ground (estimate 1 block = 500 Ft.)? Number of Blocks: _____

2. Do you require Personal Care Attendance (PCA) to escort you when traveling?

3. If you checked YES, please list the name(s) of your PCA (agency or escort):

Name: _____ Adress: _____ Home/ Cell Phone: _____

Name: _____ Adress: _____ Home/ Cell Phone: _____

Name: _____ Adress: _____

Email Address: _____

Emergency Contact:

Name: _____ Relationship: _____ Contact No.: _____

4. Does your disability prevent you from getting to or from your house to your driveway?
☐ Yes ☐ No if **YES** please explain: **(MUST COMPLETE)**

_____

_____

_____

5. My condition is: ☐ Permanent ☐ Long-Term ☐ Temporary _____
(Expected Duration)

6. Is your ability to travel or to wait outdoor affected by extreme cold or hot weather condition?
☐ Yes ☐ No If YES, please describe conditions you can't tolerate.

_____

_____

_____

7. Are you able to board or disembark from COTA Vehicle with a wheelchair lift?

☐ Yes ☐ No ☐ If No, please explain:

_____
_____
_____

8. Are you able to get around independently without assistance?

☐ Yes ☐ No ☐ If NO, please explain:

_____
_____
_____

9. Are you able to understand and follow directions?

☐ Yes ☐ No ☐ If NO, please explain:

_____
_____
_____

In order for COTA to evaluate your application, it is necessary to contact a healthcare professional to verify the inform that you have provided, Your signature on the following page will provide the authorization:

Please list the names of a healthcare professional (licensed physician, therapist, social worker, nurse, certified or registered specialist) designated by the applicant, who must be contacted by COTA.

Name of Health Care Professional: _____

Office/ Mailing Adress: _____

City: _____ State: _____ Zip Code: _____ Telephone: _____

I herby certify that the information provided in this application is correct. I authorize release of information and photos to the Commonwealth Office of Transit Authority (COTA). I also authorize COTA to contact the health care professional who completed Section 3 of this section to release information regarding my disability to COTA. The information about my disability will be used solely to determine my eligibility for paratransit services.

Print: _____ Sign: _____ Date: _____

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

Full Name (Print): _____ Telephone: _____
Mailing Adress: _____City: _____ State: _____ Zip Code: _____
Relationship to Applicant: _____

I herby verify that the best of my knowledge the information given above is correct and can be verified by the applicant's health care professional.

Signature: _____ Date: _____ (mm/dd/yyy)

Please give direction and draw a map to your residence.

FOR United States MILITARY VETERANS

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

You have now completed the application section of 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 around the community.

The attached applicant has applied for ADA Paratransit Services with the Commonwealth Office of Transit 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 COTA vans are lift-equipped for individuals who use wheelchair, scooter, or unable to use the steps. COTA provided the paratransit (Curb-to-Curb) services 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 verification of paratransit eligibility form. If you have any question regarding ADA Paratransit eligibility, please contact the Commonwealth Office of Transit Authority at (670-236-2682).

I have reviewed the enclosed application and I Agree/ Disagree with 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: Condition with potential for improvement or long periods of remission.
Permanent: Conditions with no expectation of improvement.

I hereby certify the above information is true. False verification may result in the disqualification of the applicant.

Full Name (Print and Sign): _____ Telephone: _____