



Specialized Services Application

Please complete this application entirely. Incomplete applications will be returned.

Section 1 General Information

Name _____ Home #: _____

Street Address _____ Work #: _____

City _____ State _____ Zip _____ TDD/TTY: Yes No

Mailing Address _____

City _____ State _____ Zip _____

Date of Birth _____ Current Age _____ Male Female

Is there someone to contact in the event of an emergency? Yes No

Name _____ Relationship to Applicant: _____

Street Address _____ Home #: _____

City _____ State _____ Zip _____ Work #: _____

VanGO services you are applying for?

Door to Door Service for seniors and/or disabled Dialysis Transportation

Reduced Fare Card Senior Center Transportation

For Office Use Only Specialized Service Authorization

ADA Demand Response Reduced Fare Card Subscription Service Update

Recommendation:

Approval

Denial _____
Transportation Services Supervisor

Transportation Development Administrator

Notes

Section 2 Disability Information continued

Training

Please answer all applicable questions.

1. Would mobility training allow you to utilize VanGO's public transit system?

YES NO If no, why not ? _____

2. If visually impaired, would visual impairment training allow you to use VanGO's public transit system ? YES NO If no, why not ? _____

3. Please detail how adverse weather effects your disability.

Adverse Cold (below 35 degrees) _____

Adverse heat (above 85 degrees) _____

4. Are you currently taking or scheduled to take therapy for your disability? Yes No

If so, How long will your therapy last. _____ Until _____

Section 3 Service Information

Destinations

Please list your most frequent destinations.

Note: Eligibility determinations are partly based on location, so please identify all possible destinations for consideration.

Destination	Address	Frequency	How do you get there now

2. Are you able to travel from your door to the curb or driveway without human assistance?

Yes No If no, please explain: _____

3. What is the nearest major intersection to your home? _____

4. Directions to your home: _____

5. Please identify any physical barriers between your house and the nearest VanGO stop that prevent you from using VanGO's public transit system. _____

Dialysis Patients Only

Dialysis Center Attending _____

Days you currently attend _____

Shift or time assigned _____

Section 4 Applicant Certification

I certify that the preceding information is true and correct. I authorize VanGO to verify the information and to use any information provided to arrange transportation service, including sharing information with drivers and/or contacting my physicians or other professionals regarding my request for specialized transportation.

Signature: _____

Date: _____

Optional:

I authorize VanGO to share relevant information with Emergency Management personnel in the event of a wide-spread disaster or emergency in order to assist with the provision of emergency services.

Signature: _____

Date: _____

If this application was completed by and or authorized by someone other than the individual requesting the specialized service, please complete the following:

Name _____ Relationship to applicant: _____

Street Address _____ Home #: _____

City _____ State _____ Zip _____ Work #: _____

Reason applicant was unable to complete individually: _____

Signature: _____

Date: _____

Section 5 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 VanGO provide paratransit services 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 VanGO paratransit service, a person must be unable to use regular public transit due to a physical or mental disability. Individuals qualify if:

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

PLEASE NOTE: This does not include persons who find it uncomfortable or difficult to get to and from bus stops.

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

Are there other effects of the applicants 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 applicants disabilities:

- Permanent Temporary until _____
 Unknown

Is this applicants disability affected by the weather? If so, please explain how. _____

Request for Professional Verification, continued

The Applicant can:	Fully	With Some Difficulty	With Extreme Difficulty	Not at All
<input type="checkbox"/> Walk without assistance				
Walk 200 feet (1 Block) without assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk 400 feet (2 Blocks) without assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk 600 feet (3 Blocks) without assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk 1320 feet (1/4 mi) without assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk 2640 feet (1/2 mi) without assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk 2960 feet (3/4 mi) without assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<input type="checkbox"/> Travel with a mobility aid				
Travel with a mobility aid (cane, walker, wheelchair)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Travel 200 feet (1 Block) with the use of a mobility aid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Travel 400 Feet (2 Blocks) with the use of a mobility aid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Travel 600 feet (3 Blocks) with the use of a mobility aid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Travel 1320 feet (1/4 mi) with the use of a mobility aid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

All Applicants				
Board or disembark a VanGO Bus independently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recognize vehicle markings without assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wait at a location without shelters and/or benches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plan trip and interpret schedules independently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plan trip and interpret schedules with assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Professional's Name: _____ Office #: _____
 Occupation/Title: _____ Fax #: _____
 Organization: _____
 Street Address _____
 City _____ State _____ Zip _____

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

Signature: _____ Date: _____

Return application to

Please ensure the application is completed and signed.

Mail to: Charles County Department of Community Services
 VanGO Transportation
 8190 Port Tobacco Road
 Port Tobacco, MD 20677

Contact Information

For Questions/Concerns: 301-934-9305, ext. 5110
 301-932-6004, ext. 5110
 301-870-3388, ext. 5110

Relay Service TDD: 1-800-735-2258

For Service/Reservations: 301-609-7917