



RECERTIFICATION APPLICATION FOR ALEXANDRIA DOT PARATRANSIT SERVICE

This form is for people who have previously been approved for Alexandria DOT paratransit service under the Americans with Disabilities Act (ADA) and wish to renew their eligibility. If you have not been previously certified for Alexandria DOT service, please use the Application for Alexandria DOT Paratransit Service instead of this form. Eligible riders may be required to recertify every two years. Recertification ensures the information on file is up to date and the person still resides in the City of Alexandria.

The information obtained in this recertification process will only be used by the City of Alexandria to review your eligibility to continue to use DOT Paratransit services.

Application Process

1. Fill out this application if you have already been certified to use Alexandria DOT, but your certification has or will expire.
2. Submit the completed application form (Parts A and B) to the City:
Mail: **City of Alexandria
DOT Paratransit
421 King Street, Suite 230
Alexandria, VA 22314**
Fax: **703.746.6433**
Email: **paratransit@alexandriava.gov**
3. DOT will notify you of your eligibility status.
4. **If you have not been notified within 21 days of submitting your application**, call 703.836.5222 Voice, or Virginia Relay 711. If determination of your eligibility has not been made, you will be temporarily eligible for paratransit service.
5. If you are denied eligibility, you have a right to appeal. Information on the appeals process will be sent to you. Call 703.836.5222 Voice; or Virginia Relay 711 for more information.

Applicant Information

Name: _____ Date of Birth: _____
Last First M.I.

Address of where you will be residing when using the DOT service:

Street Address Apartment/Unit #

City State ZIP Code

Phone: _____ Email: _____

Is the address provided your legal residence?

☐ YES ☐ NO

If no, then provide your legal residence below:

Street Address Apartment/Unit #

City State ZIP Code

Emergency Contact

In Case of Emergency, who should we contact?

Name: _____

Relationship (Family, Neighbor, etc.) _____

Phone (work): _____ Phone (cell): _____

Recertification

I certify that my disability is:

- ☐ Temporary: Expected duration until ____/____/____
- ☐ Long-term: Conditions with potential for improvement or long periods of remission.
Expected duration until ____/____/____
- ☐ Permanent: Conditions with no expectation of improvement.

Mobility Aids

Will you use any mobility aids when you ride paratransit?

- ☐ YES ☐ NO

If yes, check all that apply:

- | | | |
|--|---|-------------------------------------|
| ☐ Manual wheelchair | ☐ Service Animal | ☐ Cane |
| ☐ Powered wheelchair | ☐ Oxygen Bottle | ☐ White Cane |
| ☐ Bariatric wheelchair
over 30" wide and/or 42" long | ☐ Communications board | ☐ Walker |
| ☐ Powered scooter | ☐ Transfer board | ☐ Crutches |
| ☐ Hearing aid | ☐ Boarding chair | ☐ Prosthesis |
| ☐ Other: _____ | | |

If you use a wheelchair or scooter, are you willing to transfer to a seat in the vehicle?

- ☐ YES ☐ NO

Personal Care Attendant

Do you require a Personal Care Attendant when you travel? (You are responsible for providing your Personal Care Attendant)

- ☐ YES ☐ NO

Disability Information

What is your disability? _____

Is there anything else regarding your disability that we need to be aware of to provide appropriate paratransit service? Please provide any information that would help.

Travel Training

Travel training may help you use the fixed route bus and Metrorail systems for specific routes or for all routes. Travel training professionals may be available to work with you (and your specific disability) free of charge. For more information about travel training, call 703.836.5222 Voice, or Virginia Relay 711.

☐ Please check here if you are interested in travel training.

Disclaimer and Signature

DOT reserves the right to require additional information from a healthcare provider. If DOT requires additional information from a healthcare provider, you will be notified and provided the required form for your provider to complete.

I certify that my answers are correct to the best of my knowledge.

Signature

Date

OR I am not the applicant, but have completed this application on the applicant's behalf, and certify that the application is correct to the best of my knowledge:

Signature

Relationship to Applicant

Printed Name

Date

Daytime Phone

Describe below how this person has legal authority to sign this form: