



**ADA PARATRANSIT**  
**TEMPORARY ELIGIBILITY REQUEST**  
MATERNAL AND INFANT HEALTH (M.I.H)



You have requested temporary eligibility for Access Link as a part of an initiative in collaboration with the New Jersey's Maternal and Infant Health Committee. This initiative is **strictly** reserved for customers presenting with an immediate short-term need for transportation assistance due to a disability or impact of serious health condition related to pregnancy.

As required by the Americans with Disabilities Act (ADA), the presenting disability or health condition must be impacting a major life function and preventing you from using NJ TRANSIT's local fixed-route system to travel. In order for your request to be considered you must provide all required information. This application can also be submitted to NJ TRANSIT via fax 973.863.4522 or email at [ADACERT@njtransit.com](mailto:ADACERT@njtransit.com).

Our goal is to process this request within one (1) business day, when possible.

Do you have a legal guardian?  No  Yes If yes, your legal guardian must provide his or her written consent for you to participate in this process.

Legal Guardian Name (PRINT) \_\_\_\_\_

Legal Guardian Phone Number: \_\_\_\_\_

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

Name: Ms. Mrs. \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_

Mailing Address: \_\_\_\_\_

*(If same as above leave blank)*

\_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Date of Birth \_\_\_\_\_ Email \_\_\_\_\_

Please provide the name of someone who you authorize NJ TRANSIT to contact in the event of an emergency.

Name \_\_\_\_\_

Phone \_\_\_\_\_

Relationship \_\_\_\_\_

1. What is your temporary disability? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Which of the following are impacted by your temporary disability? (*check all that apply*)

Physical Ability       Cognitive Ability       Vision       Hearing


3. What is the expected duration of your temporary disability?  
from: \_\_\_\_\_ to: \_\_\_\_\_.

4. How are the conditions and limitations related to your temporary disability preventing you from using the local fixed-route system to travel to and/ or from your intended destinations? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Which, if any, of the following mobility or assistive devices do you use while traveling?

- |  |                                   |   |
|--|-----------------------------------|---|
| <input type="checkbox"/> Orthopedic Cane | <input type="checkbox"/> Braces   | <input type="checkbox"/> Manual Wheelchair    |
| <input type="checkbox"/> Scooter         | <input type="checkbox"/> Crutches | <input type="checkbox"/> Motorized Wheelchair |
| <input type="checkbox"/> White Cane      | <input type="checkbox"/> Walker   | <input type="checkbox"/> Service Animal       |
| <input type="checkbox"/> Oxygen          | <input type="checkbox"/> None     |   |

6. We require the measurements and approximate weight of your manual wheelchair, scooter and/or motorized mobility device (*while occupied*).

 wheelchair/scooter / motorized mobility device measurements

Width \_\_\_\_\_"

Total Length \_\_\_\_\_"

Combined weight of customer and mobility devices\* \_\_\_\_\_lbs

\*Mobility devices exceeding 30"X 48" or more than 600 lbs. may not fit on our vehicle lifts.

7. Do you require the assistance of another person (besides the trained driver) while traveling?  Yes  No

If yes, what assistance will this person provide for you while you are traveling? \_\_\_\_\_  
\_\_\_\_\_

8. Do you require information sent to you in an alternative format? If so, select one of the following:  Large Print  Audiotape

9. You may be required to have a medical doctor verify your present temporary medical condition. If required, please have a medical verification faxed to 973.863.4522 This verification must:

- be dated within the past 12 months
- verify your medical conditions
- verify the expected duration of your temporary disability
- be on the health care professionals' letterhead
- be signed by the health care professional

10. Please provide the addresses for where you intend to travel. *All address must be within 3/4 of a mile of a NJ TRANSIT local bus route. Access Link only travels in the same areas and during the same times as the local fixed-route system.*

1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	



---

*Access Link supports voter's rights and we are committed to helping reduce barriers that could prevent you from voting.*

---

11. Do you require assistance with registering to vote?  Yes  No  
If yes, call 973-491-4224 and select option 1 and then option 5 or email [adanvra@njtransit.com](mailto:adanvra@njtransit.com) for assistance.

12. Are you already registered to vote at the address where you reside?  
 Yes  No

To the best of my knowledge, the information that I have provided is accurate. I understand that if my disability is not considered to be temporary I can opt to participate in the full eligibility process for Access Link. The full process includes a telephone interview. The information provided within this request cannot be used to circumvent or by-pass NJ TRANSIT's established process for full paratransit eligibility consideration.

\_\_\_\_\_  
Signature of Customer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

Once we have received all required information, we will make a determination about your ability to use Access Link while you recover from your temporary disability or medical condition. All ADA paratransit eligibility determinations are communicated in writing.