County of Roanoke

Department of Social Services
CORTRAN
COUNTY of ROANOKE TRANSPORTATION

Joyce W. Earl
Director

CORTRAN: P.O. Box 1127, Salem, VA 24153 **PHONE:** (540) 776-7271
FAX: (540) 283-6750 **EMAIL:** CORTRAN@roanokecountyva.gov

Si necesita una aplicación en español, por favor visite, https:www.roanokecountyva.gov/CORTRAN

Check one: New Application ____ Recertification ____
Please check ALL that apply regarding your eligibility to utilize the CORTRAN service: Permanent Disability _____ Temporary Disability _____ 70 years or older ____

SECTION 1. CLIENT INFORMATION

1. First Name: _____Last Name: _____ Gender: _____
   Roanoke County Address:_____
   City: _____State: _____ Zip Code: _____
   Date of Birth: _____ Phone Number: _____Veteran: _____

   Optional demographics: __White __ Black or African American __Hispanic/ Latino or Spanish
   __Asian __ American Indian/ Alaskan Native __ Native Hawaiian or other Pacific Islander
   Other_____

2. Complete this section ***ONLY if Current Address is Temporary*** *(nursing home, rehab facility, or hospital)*
   Facility Name: _____
   Address: _____
   City: _____State: _____Zip Code: _____Phone Number: _____

   *Are you currently in a facility, such as a rehabilitation or assisted living facility, where transportation services are available? ___Yes___ No
3. Emergency Contact
   Name: _____
   Home Address: _____
   City: _____State: _____Zip Code: _____
   Primary Phone: _____ Secondary Phone: _____
   Relationship to Client: _____

SECTION 2: NEEDS ASSESSMENT

1. Do you have a disability that limits you from providing your own transportation? ___Yes___ No If yes, please explain limitations and accommodations needed:
   _____
2. Is this disability temporary? ___Yes ___ No
3. If yes, how long do you expect to be limited from providing transportation?
   _____

4. Do you use any of the following mobility aids or specialized equipment?

- ☐ Cane
- ☐ Crutches
- ☐ Walker
- ☐ Service Animal
- ☐ Power Scooter
- ☐ Leg Braces
- ☐ Portable Oxygen
- ☐ Powered Wheelchair
- ☐ Manual Wheelchair
- ☐ Long White Cane
- ☐ Oversized Wheelchair
- ☐ Prosthesis
- ☐ Other, please specify: _____

5. Do you require a personal care attendant to ride with you for trips? ___ Yes ___ No
If so, Name:
_____

**Only one personal care attendant may ride with you, no other guest is permitted on the vehicle.

6. Did someone other than the applicant complete this application? ___Yes ___ No

If yes, please complete the following information:

Name: _____ Facility: _____
Primary Phone: _____Relationship to Applicant: _____
Do you have Power of Attorney for the Applicant? ___Yes ___ No

I certify that the information provided on behalf of the applicant is correct and truthful to the best of my knowledge.

_____ _____

Applicant or Family Member/Responsible Party Signature **Date**

Title VI Public Notice

Roanoke County is committed to ensuring that no person is excluded from participation in, or denied the benefits of its transportation services on the basis of race, color or national origin, as protected by Title VI of the Civil Rights Act of 1964. If you feel you are being denied participation in or being denied benefits of the transportation services provided by Roanoke County's, CORTRAN Program, or otherwise being discriminated against because of your race, color, national origin, gender, age, or disability, you may contact: Paula Benke, PO Box 1127 Salem, VA. 24153, Phone (540) 776-7271, Fax (540) 283 -6750 or email CORTRAN@roanokecountyva.gov.

SECTION 3: CERTIFICATION AND POLICY AGREEMENT

I certify that the information contained in this application is correct and truthful to the best of my knowledge. I understand that the purpose of this application is to determine whether I am eligible to use the transportation services provided by CORTRAN.

By signing, I agree to report any change in my circumstances regarding eligibility for CORTRAN services to CORTRAN as soon as I am aware of such change. Further, I understand that documentation of all eligibility factors may be required to determine my eligibility or for auditing purposes and that knowingly giving false statements may result in disqualification from participating in the CORTRAN program.

I acknowledge that I understand that CORTRAN enforces the following policies:

- No Show Policy and Failed Payment Policy. See attached policies.
- Service will be approved for 2 years, after that period, clients must recertify. Individuals meeting eligibility based on a temporary disability must recertify every 6 months. A new application must be completed to recertify. It is the responsibility of the client to initiate the recertification process.
- There is no charge for ONE personal care attendant to accompany a CORTRAN client. An individual who is certified as a CORTRAN client is NOT permitted to act as a personal care attendant for another CORTRAN client. CORTRAN riders may not take "guests" on trips.
- All CORTRAN passengers must have ride credits available to schedule and take a ride.
- Service is provided curb to curb and at no time will a driver enter a building to provide assistance. A driver will provide limited assistance during boarding and exiting the CORTRAN vehicles.
- Please provide documentation to verify age, Roanoke County residency, and have a medical professional complete the Certificate of Disability if under the age of 70.
- By signing, I acknowledge and agree that information which is collected through my application for the use of CORTRAN, including demographic information and information about the rides that I take, will be accessible to both the County of Roanoke and Via, and will be used to help administer and provide the service.

_____ _____

Applicant or Family Member/Responsible Party Signature **Date**

_____ _____

Phone Number **Email Address**

***** Please allow up to five business days to process the application. Applications will not be processed without current documentation being provided.**

CORTRAN

County of Roanoke Transportation

Certification of Disability Form

The purpose of this form is to provide written, independent verification that the applicant named below has a disability according to the definition in the Americans with Disabilities Act. This form is to be completed by a medical provider who is familiar with the applicant's disability.

The applicant has applied for transportation services under the County of Roanoke Transportation program, which is being administered by Via. If you have any questions about the form, please call (540)776-7271. **Completed forms may be faxed to (540)283-6750.**

Name: _____

Address: _____

City/State: _____ Zip Code: _____
Phone: _____ Email Address: _____

_____ _____
Applicant or Family Member/Responsible Party Signature **Date**

Definition of Disability

Eligibility for this program is based on disability as defined by the Americans with Disabilities Act (ADA). According to the ADA, "Disability means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment." "...major life activities means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and work."

This section to be completed by the medical provider providing verification of eligibility information.

Is the applicant's disability permanent, lasting longer than 12 months? ____ Yes ____ No

If no, how long is it expected to last? _____

What is the nature of the applicant's disability?

_____ Mobility Disability (See question at right)
_____ Vision Disability
_____ Hearing Disability
_____ Cognitive Disability
_____ Other, specify: _____

Please check all mobility aids that apply.

_____ Manual wheelchair
_____ Power wheelchair
_____ Motorized Scooter
_____ Guide/Service Dog
_____ Requires Personal Attendant
_____ Crutches
_____ Cane
_____ Walker
_____ White Cane

Name of Medical Professional:

_____

Agency/Organization: _____

Address: _____ Phone: _____

_____ _____
Medical Provider Signature **Date**