REQUEST FOR APPEAL OF ADA ELIGIBILITY DETERMINATION

You have the right to appeal the determination of your eligibility for START ADA Complementary Paratransit Bus Service. Your request for review must be made within sixty (60) days of the date of your eligibility determination.

For your **Request for Appeal** to be considered, this form and supporting documentation must be returned, postmarked on or before 60 days of your eligibility determination. Your request will not be considered if postmarked after this date.

ID# _____

(PLEASE PRINT)

_____

Address:_____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Secondary Phone: _____

Designated Advocate, if any: _____

Advocate Phone (Daytime): _____

You may submit any written materials regarding your disability and your functional ability to use accessible fixed route bus service for START bus service as part of this Request for Appeal. Any written material that you submit will become part of your Request for Appeal file and cannot be returned.

ELIGIBILITY CAN BE DETERMINED BY ONLY THREE CATEGORIES: (USDOT 37.123)

1. **UNABLE TO UNDERSTAND HOW TO COMPLETE BUS TRIPS DUE TO A COGNITIVE DEFICIENCY.**
2. **REQUIRE A LIFT-EQUIPPED BUS AND THE BUS YOU NEED DOES NOT HAVE A LIFT. (DOES NOT APPLY IN JACKSON AREA.)**
3. **UNABLE TO INDEPENDENTLY GET TO AND FROM A BUS STOP OR CANNOT GET ON AND OFF THE BUS. (LIFT CAN BE UTILIZED BY AMBULATORY.)**

The START ADA Certification Panel will consider your request and you may expect a reply within thirty (30) days of the date your request is received**.**
YOU WILL BE NOTIFIED OF THE MEETING OF THE APPEALS COMMITTEE BY MAIL.

YOU ARE STRONGLY ENCOURAGED TO ATTEND.

Check One

- ☐ ADA Complementary Paratransit service eligibility was **denied** – Appealing *denied* eligibility decision.
- ☐ **Conditional** ADA Complementary Paratransit service was granted – Appealing for *Unconditional* ADA Complementary Paratransit service eligibility.
- ☐ **Temporary** ADA Complementary Paratransit service was granted – Appealing for *Permanent* ADA Complementary Paratransit service eligibility.

1. Please explain why you disagree with the decision made concerning your Paratransit eligibility. You may use additional sheets if necessary.

2. Is there any information which was not presented in your original application that you would like to have considered? This may include, but is not limited to, current information from your physician, a family member or an agency from which you receive service. Please check one:

_____ I have attached additional information from:

Name:
Address:

Name:
Address:

_____ I have no additional documentation to submit.

I understand that the above information and my application file will be made available to the members of the START ADA Certification Panel for their consideration. You have my permission to contact my physician or the agencies from which I have received service (if part of the Request for Appeal), to confirm the information I have provided. I certify that the information I have provided is correct.

_____ _____
Signature Date

If this Request for Appeal has been completed by someone other than the person requesting review, please complete the following:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone: _____

Relationship to Applicant: _____

Signature: _____ Date: _____

This completed Request for Appeal should be mailed to:

***ADA Program* at**
START Bus / Town of Jackson
Attention: Appeal Coordinator
P.O. Box 1687
Jackson, WY 83001
info@startbus.com