



# CORTTRAN Application

CORTTRAN  
P.O. Box 29800  
Roanoke, Virginia 24018  
EMAIL: [CORTTRAN@roanokecountyva.gov](mailto:CORTTRAN@roanokecountyva.gov)

PHONE: (540) 776-7271  
FAX: (540) 283-6750

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

**Check one: New Application  Recertification**

**Please check ALL that apply regarding your eligibility to utilize the CORTTRAN service:**

Permanent Disability  Temporary Disability  65 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  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?  
\_\_\_\_\_

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

<input type="checkbox"/> Cane	<input type="checkbox"/> Powered Wheelchair
<input type="checkbox"/> Long White Cane (Visually Impaired)	<input type="checkbox"/> Manual Wheelchair
<input type="checkbox"/> Crutches	<input type="checkbox"/> Oversized Wheelchair
<input type="checkbox"/> Walker	<input type="checkbox"/> Power Scooter
<input type="checkbox"/> Prostheses	<input type="checkbox"/> Larger Mobility Device
<input type="checkbox"/> Leg Braces	<input type="checkbox"/> Service Animal
<input type="checkbox"/> Portable Oxygen	<input type="checkbox"/> Personal Care Attendant

5. Please list the name of the Personal Care Attendant: \_\_\_\_\_

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

6. In order for the CORTAN service to transport you safely and comfortably, please include your approximate weight along with any **special equipment** or instructions to transport you below.

Weight: \_\_\_\_\_ Special instructions: \_\_\_\_\_

If someone other than the applicant completed this application, please complete the section below.

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.

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

**Date**

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

## **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, CORTAN Program, or otherwise being discriminated against because of your race, color, national origin, gender, age, or disability, you may contact: Kristie Jordan, 5204 Bernard Drive, Roanoke, Virginia 24018, Phone (540) 283-8109, or email [kjordan@roanokecountyva.gov](mailto:kjordan@roanokecountyva.gov).

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## SECTION 3: CERTIFICATION AND POLICY AGREEMENT

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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 CORTAN.

By signing, I agree to report any change in my circumstances regarding eligibility for CORTAN services to CORTAN 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 CORTAN program.

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

- No Show Policy and Failed Payment Policy.
- Service may be approved for up to two 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 CORTAN client. An individual who is certified as a CORTAN client is NOT permitted to act as a personal care attendant for another CORTAN client. CORTAN riders may not take “guests” on trips.
- All CORTAN passengers must have a form of payment on file or ride credits available to schedule and take a ride. **Ride credits are non-transferable and non-refundable.**
- 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 CORTAN 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 65.
- **This is a ride share program with a limited number of rides available Monday through Friday. Your requested pick-up time may not be available. A form of payment must be set up prior to scheduling your ride. No payment is accepted by the driver.**
- By signing, I acknowledge and agree that information which is collected through my application for the use of CORTAN, 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.

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Applicant or Family Member/Responsible Party Signature

Date

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Phone Number

Email Address

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## 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.**

Applicant 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 mean functions such as caring for oneself, 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 for anyone under the age of 65.**

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

Name of Medical Professional:

Agency/Organization: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Medical Provider Signature**

**Date**