

LCT's REASONABLE MODIFICATION REQUEST FORM

In determining whether to grant a requested modification, Lorain County Transit (LCT) will be guided by the provisions of the Americans with Disabilities Act (ADA) as amended and the United State Department of Transportation (DOT) regulations in conjunction with the guidance provided in Appendix E of Title 49 CFR Part 37.

Name of individual requesting modification: \_\_\_\_\_

Name of individual wishing to utilize modifications: \_\_\_\_\_

Address of passenger who needs modification: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number (Home): \_\_\_\_\_ Telephone Number (Mobile): \_\_\_\_\_

Describe any modifications to LCT's policies, practices or procedures in order for you (an individual with disabilities) to access the services (attach additional sheets is necessary: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate the location (or address) where you will need the requested modification: \_\_\_\_\_

\_\_\_\_\_

Describe the problem you face that prevent you from utilizing LCT's fixed route or Dial-A-Ride Services: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This form may be dropped off in person at 226 Middle Avenue, Elyria; mailed to LCT, 226 Middle Avenue, Elyria OH 44035; or emailed to: [pnovak@loraincounty.us](mailto:pnovak@loraincounty.us)

\_\_\_\_\_

For Office Use Only:

_____ Date Received	_____ Date Eligibility Established
_____ Sent for evaluation	_____ Request Approved/Denied
_____ Response Issued	_____ Notification sent

LCT's REASONABLE MODIFICATION MEDICAL DOCUMENTATION FORM

A reasonable modification may be requested by individuals who are disabled as described by ADA. A new applicant will be required to submit documentation from his/her physician establishing ADA eligibility.

Physician Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date signed \_\_\_\_\_

Patient Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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

1. The patient listed above does/does not (circle one) have a medical condition.
2. The medical condition is \_\_\_\_\_.
3. The medical condition is permanent/temporary (circle one).
4. Please describe the reason this patient requires a reasonable modification to utilize LCT's fixed route or Dial-A-Ride service \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please return this form to Lorain County Transit secure fax at 440-329-5459 to mail to Lorain County Transit, 226 Middle Avenue, Elyria, OH 44035.