

Regional Paratransit Application

The paratransit systems in the region operate in accordance with the Americans with Disabilities Act (ADA) of 1990, and each program is designed to serve individuals whose disabling conditions or functional limitations *prevent them from using regular fixed route services*. The programs are coordinated with one another, which means that only one application needs to be completed and that customers determined to be eligible need only make one phone call to receive service, even if they will be traveling across the region. Eligible customers may make taxi, wheelchair accessible handicab, and/or wheelchair accessible van trips at a cost that is determined by each of the paratransit systems in the region. Each of these paratransit systems may also provide service at different times of the day or days of the week, and each may have different operating procedures. These differences are explained to all customers upon their being certified to use the services.

WHO IS ELIGIBLE?

Under the ADA regulations, individuals who qualify for paratransit services qualify for at least one of following three categories:

1. The individual is unable, as a result of mental or physical impairment as defined in the ADA, to get on, ride, or get off an accessible vehicle on the fixed route bus services;
2. The individual needs the assistance of a wheelchair lift or other boarding device and is able, with such assistance, to get on, ride, and get off an accessible vehicle on the fixed route bus services, **BUT** such a vehicle is not available on the route when the person wants to travel;
3. The individual has a specific impairment-related condition (including limitations of vision, hearing or disorientation), which prevents travel to or from a transit station or bus stop on the fixed route bus services.

WHAT ELSE SHOULD YOU KNOW?

1. Individuals who can access and use the regular fixed route bus services are not eligible to use the paratransit services.
2. In situations where demand responsive connector services are available and accessible to the individual, paratransit services will not be provided.
3. The paratransit services operate only within certain service areas. If you are eligible to use the paratransit services, but live outside of the service areas, *you are responsible for any transportation needed to arrive within the service areas*.
4. If the applicant is determined to be eligible for the paratransit services, one of two designations may be made: Unconditional or Conditional. **Unconditional eligibility** indicates that the applicant can use the paratransit services for all trips within the service areas. **Conditional eligibility** indicates that some trips are eligible and some not, based on functional ability to use the regular fixed route bus services given the specific environment and demands of each trip.

HOW DO I APPLY?

1. Keep this page and the previous page of the application for your information and records.
2. If you believe you qualify for the paratransit services, complete Part A of this application.
3. Provide **both parts A & B** of this application to an authorizing professional. Both parts of the application must be completed in order for your application to be considered.
4. Mail the completed parts A & B to:

Name
Address
Address

Phone: If you use a TDD, call 1-800-735-2962 and ask to be connected to:

WHAT HAPPENS AFTER I TURN IN MY APPLICATION?

1. After your application is received, you will be contacted within 21 business days by staff to schedule a functional assessment.
2. A staff person will then will visit you in your home or work setting, or schedule you for a free trip to and from a functional assessment center, so as to determine your eligibility based on the following factors:
 - a. Information provided on your application.
 - b. Information provided by your authorizing professional.
 - c. Results of a brief assessment of your actual functional abilities.
 - d. A review of available transportation options in the areas in which you desire to travel.
3. If you have questions or have not been contacted within 21 city business days of submitting your application, call the phone number(s) listed above. If, at that time, a determination of your eligibility has not been made, you will be temporarily eligible for the paratransit services until such time as your application can be reviewed.
4. If you are denied paratransit service eligibility, you will receive a letter regarding this decision and a copy of an appeals process. You have the right to appeal. For more information, call the phone number(s) listed above

This application is available in alternative formats. If you would like additional assistance, please call the phone number(s) listed above. The information in this application will be used only to determine your eligibility for paratransit services and will be kept confidential by the participating paratransit systems.

PART A

Please complete the following information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Birth date: ____/____/____ SSN: _____

Home telephone number: _____

Work/other daytime telephone number: _____

If hearing impaired, TDD number: _____

Language ability (please check all that apply):

____ English ____ Spanish ____ Other (specify): _____

Do you currently use any regular fixed route bus services of any demand responsive connector services? ____ NO ____ YES

If yes, which routes? _____

What is the closest bus stop to your home? _____

Can you get to the bus stop by yourself? ____ NO ____ YES

If no, what limits you from getting there? _____

Name any regular fixed routes or connector routes, which serve your neighborhood:

Please check ONE of the following seven statements on the next two pages, which best defines the nature of the disability or limitation which prevents you from using fixed route bus service. Describe your specific needs in the space provided:

(MOB)

I have a mobility impairment, which prevents me from getting to and/or getting on a fully accessible vehicle without assistance. Describe the nature of this condition and any environmental obstacles (such as inclines, curbs, and distances) which affect your ability to access public transportation: _____

This condition is: _____temporary _____permanent

(END)

I have an endurance problem, which prevents me from moving the distance needed to get to the bus stop. Please describe the cause and nature of this condition: _____

This condition is: _____temporary _____permanent

(VIS)

I have a visual impairment that prevents me from finding my way to and from a fixed route bus stop without assistance. Describe the nature of your condition and your functional level of vision: _____

Please list any specific trips for which you have received travel training, and the name of the Orientation and Mobility specialist who provided the training: _____

(COG)

I have a cognitive disability which prevents me from remembering and understanding information needed to get myself safely to and from the bus stop. Please describe the origin and characteristics of your condition: _____

Are you involved in any programs or training, which will have an impact on your ability to use public transportation? If so, please describe: _____

(OTH)

I have a severe medical condition, which limits my ability to function. Please describe and note whether your condition is temporary or permanent, and if it is episodic in nature (i.e. do you have "good" days or times when you can access transportation, and "bad" days when you cannot?) _____

I am dealing with functional losses due to aging. I feel I am not able to access regular bus service due to the following limitations:

(OTH)

Other. My functional limitations do not fit into any of the above categories. I am unable to use regular bus service because:

(OTH)

This condition is _____temporary _____permanent

Please check any of the following Environmental or Individual Factors which are applicable to your situation:

If I am waiting outside at a bus stop, I must have:

_____ a bench _____ a shelter _____ nothing additional

When crossing a street, I need:

_____ curb cuts _____ tactile curb warnings _____ audible signals
_____ accessible median _____ no more than # _____ lanes of traffic

I cannot make my way across ground which is:

_____ paved or sidewalk _____ grassy _____ gravel _____ hilly

My ability to access transportation is affected by weather which is:

_____ warm (above _____ degrees) _____ cold (below _____ degrees)
_____ rainy _____ icy _____ windy

My ability to access transportation is dependent on the time of day. I cannot see in:

_____ full daylight _____ partial light _____ darkness/ semi-darkness

My ability to access stairs is as follows. I can manage:

_____ only one or two steps _____ only with a handrail _____ no steps

The distance I can travel to and from bus stops is:

_____ no more than _____ feet _____ at least five blocks

I can wait at a bus stop:

_____ no more than _____ minutes _____ at least one hour

The bus stops which I can access:

_____ must be stops for which I have received formal travel training
_____ must be only in areas familiar to me

I travel:

alone both alone and with a companion
 only with an attendant or companion (this does NOT affect eligibility)

If you travel with someone who assists you, does this person assist you in:

getting to or from bus stops getting on or off the bus
 helping me where I am going
 other (describe): _____

I can cross a street with:

2-3 lanes 4-6 lanes I cannot cross

List your 5-6 most frequent destinations and how you currently get there:

Destination	Frequency of travel	How you get there now:

List places you would like to go but cannot currently access:

Destination	Frequency Desired	Barriers to your access

Which of the following mobility aids do you use? (please check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Cane | <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Service animal |
| <input type="checkbox"/> White Cane | <input type="checkbox"/> Powered Wheelchair | <input type="checkbox"/> Picture board |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Powered scooter/cart | <input type="checkbox"/> Alphabet board |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Boarding chair | <input type="checkbox"/> Portable oxygen |
| <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Transfer board | <input type="checkbox"/> None of these |
| <input type="checkbox"/> Other (describe): _____ | | |

If you use a manual or powered wheelchair or scooter, what year, make, and model is it? _____

If you use a manual or powered wheelchair or scooter, is it more than 30 inches wide, more than 48 inches long, or does it, when in use weigh more than 600 pounds (person plus mobility device)? Yes No

PART B of this application begins on the next page and must be filled out by a health care or human services professional who is familiar with your disabling condition and/or functional limitation. Your signature on the application authorizes this professional to provide information to the participating paratransit systems regarding your eligibility for ADA paratransit services and any needed clarification of functional limitations due to your disabling condition.

In the space provided below, **CLEARLY PRINT** the name of the professional who will be verifying your application, and specify his/her position.

Name of professional: _____

Professional affiliation (check the appropriate designation):

- | | |
|---|--|
| <input type="checkbox"/> Licensed physician | <input type="checkbox"/> Licensed physical therapist |
| <input type="checkbox"/> Licensed occupational therapist | <input type="checkbox"/> Licensed social worker |
| <input type="checkbox"/> Nurse (LPN or RN) | <input type="checkbox"/> Certified psychologist |
| <input type="checkbox"/> Certified rehabilitation counselor | <input type="checkbox"/> Speech pathologist |
| <input type="checkbox"/> Vision specialist | <input type="checkbox"/> Orientation/mobility specialist |
| <input type="checkbox"/> Audiologist/ Hearing specialist | <input type="checkbox"/> MR/DD qualified specialist |

I certify that the information contained in this application is correct and I hereby authorize the above-named professional to provide verification of my condition and supporting information as needed:

Applicant's signature: _____

If you were assisted by someone else to complete this Part A, please list contact information below:

Name: _____	Daytime phone: _____
Address: _____	
Relationship to applicant: _____	
SIGNATURE: _____	

Your emergency contact (if different from person assisting you with application):

Name _____ Daytime phone: _____

PART B

You are being asked by the applicant named in PART A of this application to provide information regarding his/her ability to use the regular fixed route services provided by the transit systems in the region. For those persons who cannot use the regular fixed route services, the transit systems will allow them to use the paratransit services that are also provided. The information you provide will allow us to evaluate the request and determine this individual's specific needs. Thank you for your cooperation in this matter.

Please note:

All regular fixed route and connector services available within the region are currently accessible to persons with disabilities who need lift-equipped vehicles, vehicles which kneel to the curb, and/or announcement of bus stops. In order to be eligible for the paratransit services, therefore, the individual must be **unable** to access these services due to conditions which prevent them from getting to or from a regular fixed route bus stop, or transferring between vehicles, and/or conditions which prevent them from being able to get on, ride, or get off a lift-equipped vehicle. Individuals for whom performing these tasks is inconvenient or uncomfortable are **not eligible** for services, and you are asked to verify this information.

Eligibility for paratransit services is determined on a trip-by-trip basis. It is extremely important that you provide specific information about the individuals' **functional limitations**, so that these determinations can be made. For example, an individual who can easily and safely get to the bus stop nearest their home may not be able to get to a bus stop at their desired destination and thus would be eligible to use the paratransit services based on the destination.

Please follow these steps to verify this application:

1. Read PART A of the application in its entirety.
2. Fill out PART B of the application completely, using the criteria provided.
3. Return the completed application to the applicant within 7 days of receipt. The applicant is responsible for returning the application to the paratransit service provider.
4. Be aware that you may be contacted for further information if questions remain about the applicant's abilities.
5. If you have any questions, contact the paratransit service provider at:

Phone:

If you use a TDD, call 1-800-735-2962 and ask to be connected to:

Please complete the following:

I have read PART A in its entirety: _____ YES _____ NO

I agree with the information provided in PART A: _____ YES _____ NO

If no, please explain: _____

Identify the condition causing this applicant's disability:

Specify which functional limitations are associated with this condition and be specific when asked to supply additional information:

- | | |
|---|---|
| <input type="checkbox"/> Mobility impairment | <input type="checkbox"/> Visual impairment
__ total __ partial |
| <input type="checkbox"/> Hearing impairment
__ total __ partial | <input type="checkbox"/> Compromised endurance
__ muscular __ respiratory |
| <input type="checkbox"/> Cognitive impairment | <input type="checkbox"/> Other (please specify below)
_____ |

If this individual has functional limitations due to a cognitive impairment, please indicate any of the following issues that are pertinent to this individual:

- _____ Cannot be left alone to wait for transportation.
- _____ Displays behavior that is unsafe for self or others using public transportation.
- _____ Cannot recognize vehicles that s/he should board.

For any impairments checked above, please note specific precautions that this individual must follow in terms of:

Travel distance limitations: _____

Limitations regarding time of day to travel _____

Weather conditions: _____

Environmental conditions: _____

What is the severity of this individual's condition?

- Mild Moderate Severe
 Profound/Chronic

What is the expected duration of this individual's condition?

- Temporary: Approximate expected duration until ____/____/____
- Long-term: Potential for functional improvement or periods of remission
- Permanent: No expectation of functional improvement

Please choose the statement below which best represents your opinion regarding this individual's use of public transportation:

- This individual should be able to access public transportation successfully.
- This individual can use public transportation under certain situations as stated above.
- This individual cannot use public transportation due to multiple functional limitations.

Thank you for your assistance!!

SIGNATURE: _____

PRINTED NAME: _____

ADDRESS: _____

PHONE # _____

ORGANIZATION / PRACTICE: _____