

# ADA PARATRANSIT SERVICE ELIGIBILITY APPLICATION



## Important information for applicants

Thank you for inquiring about eligibility for ADA Paratransit Service. Paratransit Service is reserved for persons living with a disability who are unable to independently, without the help of another person, use lift-equipped fixed-route public transit, some or all-of the time, due to a health-related condition. As part of the federal requirements of the Americans with Disabilities Act (ADA), Paratransit Service is provided by all public transportation systems. Paratransit Service is a shared ride transportation service that is not dependent on trip purpose. Paratransit Service primarily serves origins and destinations within  $\frac{3}{4}$  of a mile from regular fixed-routes.

To use ADA Paratransit Service, you must apply for eligibility. Eligibility is determined on a case-by-case basis. According to ADA regulations, eligibility is strictly limited to those who have specific limitations that prevent them from using accessible lift-equipped fixed-route public transportation such as Sonoma County Transit, Santa Rosa CityBus, or Petaluma Transit, some or all of the time.

Your application may be approved for full eligibility (unconditional) or on a limited basis for some trips only (conditional eligibility.) To apply for eligibility, you must fully complete and return the attached application. Please note, if more information is necessary to make an eligibility determination, an in-person or over the phone interview, contact with your health professional, and/or request that you have a licensed professional complete the Medical Verification form (found on page 8 of this application) may be required. Although not required to apply, Medical Verification from a licensed professional may assist in determining your eligibility and may be submitted at the time of application.

Once a completed application is received, it will be reviewed within 21 calendar days. You will receive notice of your eligibility determination by mail. If you are certified as eligible, you will be eligible to travel on public paratransit services throughout the nine-county Bay Area.

If you do not agree with your eligibility determination, you have the right to appeal. Information on how to file an appeal will be included with your eligibility notice. If an eligibility determination takes longer than 21 calendar days, you may be granted temporary eligibility status that allows you to use the paratransit system until a final decision about eligibility is made. This does not apply if, through inactions on your part, we are unable to complete the processing of your application.

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## Instruction for applicants

1. Complete all of the questions on the Paratransit Application that follow this page.
2. Please print or type full responses to all of the questions. **Only complete applications will be processed.** If your application is not complete you will be notified.
3. You must provide two signatures on page 7 to complete the application:
  - Applicant Certification
  - Authorization to Release Information
4. Return the completed application to the appropriate transit agency based on your service address. Completed applications can be sent via:
  - mail
  - email
5. Please note, more information may be required to determine eligibility and you may be asked to
  - attend an in-person functional assessment or over the telephone interview
  - provide a Medical Verification form completed by a licensed professional. If you believe this form will help us determine your eligibility you may submit it with your completed application.

### Return the completed application to

Santa Rosa Residents	Petaluma Residents	All other Sonoma County Residents
<b>By Mail</b> <b>Santa Rosa CityBus Paratransit</b> Attn: Paratransit Eligibility 45 Stony Pont Rd. Santa Rosa, CA 95401	<b>By Mail</b> <b>Petaluma Transit</b> Attn: Paratransit Eligibility 555 N McDowell Blvd Petaluma, CA 94954	<b>By Mail</b> <b>Sonoma County Transit</b> 355 West Robles Ave. Santa Rosa, CA 95407
<b>By Email</b> Subject: Eligibility paratransit@srcity.org	<b>By Email</b> Subject: Eligibility petpara@cityofpetaluma.org	<b>By Email</b> Subject: Eligibility paratransit@sctransit.com
<b>For assistance with this application or for a copy in another accessible format call</b>		
707-541-7180	707-778-4540	707-585-7516

# ADA PARATRANSIT SERVICE ELIGIBILITY APPLICATION



## Instructions for applicants

Please complete **all** sections of this form. Incomplete applications will be returned. The information provided will help determine what type of transportation service is right for you. All information will remain confidential.

## Applicant Information (Please print or type)

New Application       Recertification (Existing Rider ID # \_\_\_\_\_)

Name (first, middle, last): \_\_\_\_\_

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_       Female       Male

Primary Language:     English       Spanish       Other (specify) \_\_\_\_\_

Service Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ ZIP: \_\_\_\_\_

Mailing Address (if different):

\_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ ZIP: \_\_\_\_\_

Daytime Phone: (\_\_\_\_) \_\_\_\_\_ TDD/TTY:(\_\_\_\_) \_\_\_\_\_

Evening Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone:(\_\_\_\_) \_\_\_\_\_

Email address: \_\_\_\_\_

Please send me written information in an alternate format (select below if applicable)

Large Print     Audio tape     Braille     Digital     Other \_\_\_\_\_

In case of emergency, whom should we contact (LOCAL preferred)?

Name: \_\_\_\_\_ Day Phone: (\_\_\_\_) \_\_\_\_\_

Relationship: \_\_\_\_\_ Eve. Phone: (\_\_\_\_) \_\_\_\_\_

## Person completing application if not the applicant.

Printed Name: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Daytime Phone: (\_\_\_\_) \_\_\_\_\_ Evening Phone:(\_\_\_\_) \_\_\_\_\_

Should this person be contacted if additional information is needed?     Yes     No

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Please answer the following questions in detail – your specific answers will help us in determining your eligibility.

## Tell Us About Your Disability / Health-Related Condition

1. Do you have a disability that, some or all of the time, **prevents** you from independently using public transit (fixed-route bus)?

○ **Fixed-route** bus service is a public transit service using buses to provide transportation along a designated route that stops at bus stops following a pre-determined timetable. Fixed-route bus service in Sonoma County is operated by Santa Rosa CityBus, Petaluma Transit, and Sonoma County Transit.

No       Yes

**If yes**, please describe **HOW** your condition prevents you from using a fixed-route bus (**response required**).

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2. What types of disabilities cause you to be unable to use fixed-route buses some or all of the time?

Physical disability       Developmental disability       Mental illness  
 Recent surgery       Visual impairment       Other: \_\_\_\_\_

3. Are the conditions you described:

Permanent       Temporary       Don't know

If temporary, how long do you expect this to continue?

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4. Paratransit operators are unable to perform the duties of a Personal Care Attendant (PCA). Will you need to travel with a PCA or someone to assist you when you use paratransit?

Always       Sometimes       Never

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## Using fixed-route buses

5. Do you currently use fixed-route bus service?  Yes  No  Sometimes
6. When was the last time you used fixed-route bus service by yourself? \_\_\_\_\_  
 I have never ridden fixed-route bus service.
7. Have you ever had training on how to use fixed-route bus service?  
 Yes  No
8. Are you interested in receiving travel training?  Yes  No
9. Are you able to wait at a bus stop for a fixed-route bus?  
 Yes  Only if there is a bench or shelter  
 No more than 15 minutes  No  
 Sometimes. **Description required:** \_\_\_\_\_
10. How far can you travel independently to a bus stop?  
 Less than 1 block  1 block  2 blocks  
 3 or more blocks
11. Can you maintain balance, while seated, on a moving fixed-route bus?  
 Yes  No  Sometimes
12. How do you travel now? *(Please check all that apply):*  
 Buses  Paratransit  Drive myself  Rail/Train  
 Taxi  Uber/Lyft  Bicycle  Someone drives me  
 Other: \_\_\_\_\_
13. Please add any other information you would like us to know about your abilities:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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14. What best describes your ability to use the fixed-route bus system independently?

**Check all that apply.**

The severity of my disability or health condition can change from day to day. I can ride fixed-route buses when I am feeling well, but not at other times.

**Description required** \_\_\_\_\_

I am unable to travel on the fixed-route buses during periods of darkness due to my disability or health condition.

I can get to and from bus stops only if there are curbs-cuts and level sidewalks.

I have difficulty understanding or remembering all the things I would have to do to use the fixed-route buses.

I can use fixed-route buses if it is a place I go to all of the time.

I am not really sure if I can use fixed-route buses by myself.

I am not able to use fixed-route buses by myself for other reasons:

**Description required** \_\_\_\_\_

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## Mobility aid and/or equipment information

15. Which of these mobility aids do you currently use while traveling? **Please check all that apply to you.**

No mobility aid

Support Cane

White Cane

Leg Brace

Service Animal

Speech Device

Powered Wheelchair

Powered Scooter/cart

Manual Wheelchair

Power Assist Wheelchair

Communication Board

Other (please specify): \_\_\_\_\_

Walker

Walker with Seat

Portable Oxygen

Prosthesis

Crutches

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## Applicant Certification

I **certify** that the information in this application is **true and correct** to the best of my knowledge. The purpose of this application is to determine if I am eligible to use Paratransit Services. I understand that knowingly falsifying the information could result in loss of Paratransit Services or denial of Paratransit Services as well as penalty under the law. I understand all information will be kept confidential, and only information required to provide the services I request will be disclosed to those who perform the services.

I also understand that, at no expense to me, I may be required to participate in an in-person functional evaluation of my travel skills and agree to such a functional evaluation if one is necessary.

I understand it may be necessary to contact a professional familiar with my functional abilities to use public transit to assist in the determination of eligibility or have them complete a Medical Verification form.

I agree to notify my Paratransit Service provider if my condition changes, my mobility device has changed, or if I no longer need Paratransit Services.

\_\_\_\_\_  
Signature of Applicant or Guardian if Applicable

\_\_\_\_\_  
Date

## Authorization to Release Medical Information

*(To be Completed by Applicant)*

I **hereby authorize** the following licensed professional (doctor, therapist, social worker, etc.) who can verify my disability or health-related condition to release this information to my local public transit agency. This information will be used only to verify my eligibility for Paratransit Services. I understand that I have the right to receive a copy of this authorization and that I may revoke it at any time.

<p><b>Professional who may release my medical information:</b></p> <p><b>Name:</b> _____</p> <p><b>Service they provide:</b> _____</p> <p><b>Address:</b> _____</p> <p><b>Medical Record or ID#, if known:</b> _____</p> <p><b>Telephone:</b> _____ <b>Fax:</b> _____</p>
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\_\_\_\_\_  
Signature of Applicant or Guardian if Applicable

\_\_\_\_\_  
Date

# ADA PARATRANSIT SERVICE ELIGIBILITY APPLICATION



## Medical Verification Form

**To the applicant:** A Medical Verification Form is not required to apply for eligibility. However, we may request you submit Medical Verification after reviewing your completed application if more information is needed. Applicants may submit the Medical Verification form with their completed application to aid in determining eligibility.

**MUST BE COMPLETED BY A PROFESSIONAL, NOT THE APPLICANT**

### To the Professional:

The ADA regulations state that persons are eligible for Paratransit Service if, because of a disability or medical condition, they are, sometimes or all of the time, physically or cognitively unable to (not discomforted by or find difficult) independently use accessible lift-equipped public transit service. ADA paratransit eligibility is not based on a person's lack of knowledge of bus service, distance from bus service, ability to drive, language ability, or age. The information you provide will assist in determining under what circumstances this applicant may be eligible for Paratransit Service.

### Please check your professional title:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Physician                                   | <input type="checkbox"/> Physician's Assistant | <input type="checkbox"/> Registered Nurse       |
| <input type="checkbox"/> Nurse Practitioner                          | <input type="checkbox"/> Psychiatrist          | <input type="checkbox"/> Psychologist           |
| <input type="checkbox"/> Chiropractor                                | <input type="checkbox"/> Physical Therapist    | <input type="checkbox"/> Occupational Therapist |
| <input type="checkbox"/> Social Worker                               | <input type="checkbox"/> Case Manager          | <input type="checkbox"/> Resource Manager       |
| <input type="checkbox"/> Certified orientation & mobility specialist |  |   |

**Name of Applicant:** \_\_\_\_\_ **Birthdate:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

1. Please describe the medical diagnosis, physical, or cognitive disability which causes the applicant to be unable to independently use a lift-equipped fixed-route bus some, or all of the time. **You must provide specific details or the application will be returned:**

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2. Are the conditions you described:

Permanent       Temporary       Don't know

If temporary, how long do you expect this to continue?

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3. Is this person able to self-supervise daily activities?

Yes       No

Last date of contact with this applicant: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**I certify under penalty of perjury under the laws of the State of California that the information contained in this application is true and correct.**

Signature of Professional: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Printed name: \_\_\_\_\_

Clinic/Agency: \_\_\_\_\_

Address: \_\_\_\_\_ Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Professional License /Registration/Certification #: \_\_\_\_\_ State: \_\_\_\_\_

\*This form expires 90 days from the signature date.