



ADA Paratransit Eligibility Application

For Office Use Only

Date Received:

Received By:

WHAT IS PARATRANSIT?

The Americans with Disabilities Act (ADA) is a federal law that guarantees people with disabilities full and equal access to the same services and accommodations available to people without disabilities. Under the ADA, public transportation that runs defined routes (fixed-route service) must be accessible to people with disabilities. When a passenger with a disability is not able to use the fixed-route system, the ADA mandates that transit systems provide complementary paratransit service.

For eligible riders that have a disability preventing them from making some or all their trips on the fixed-route buses, Rides Mass Transit District provides a shared ride, origin-to-destination service called paratransit. This service is available to eligible passengers. Paratransit service must be reserved at least one day in advance. Each of the vehicles used for this service are equipped with a lift to assist mobility devices.

WHO IS ELIGIBLE?

Eligibility decisions for ADA Paratransit are based on the applicant's functional ability to access and use fixed-route bus services. Each application is assessed on a case-by-case basis.

ADA Paratransit service is a "safety net" for persons with functional limitations that *prevent* them from using the fixed-route service. As described in 49 CFR 37.123(e) of the United States Department of Transportation ADA regulations, eligibility is limited to certain categories of individuals:

- Any person with a disability who is unable to board and ride from an accessible vehicle.
- Any person with a disability can utilize an accessible vehicle, but the route is not accessible.
- Any person with a disability and has a specific impairment-related condition that prevents the person from traveling to or from a boarding location on the fixed route.

The following examples **do not** automatically establish eligibility:

- The bus system does not meet your personal schedule; trips by bus take too long; buses do not serve destinations to which you travel.
- Lack of familiarity or experience with the bus system.
- Certification of a disability from SSI, SSA, or the VA.
- Living in an area not served by a regular fixed route service.
- Fear of riding fixed route service.
- Use of the bus system may be more difficult or less comfortable.

APPLICATION PROCESS

Upon receipt of a **completed** ADA Paratransit Eligibility Application, an evaluation period of up to twenty-one (21) calendar days begin. During this period, it is RMTD's responsibility to utilize the information provided by the applicant and medical professionals to determine whether they meet the criteria established in 49 CFR 37.123 (e) and are eligible for paratransit services.

If an incomplete application is received, a member of RMTD's staff will reach out to the applicant for additional information or clarification.

After a determination has been made, written notification of the applicant's eligibility status will be mailed to the address listed on their application.

APPEAL PROCESS

In the case that an applicant is not satisfied with the action taken on their application, they have the right to appeal that decision.

Appeal requests must be made within 60 days of receipt of the written notification of paratransit eligibility status. Please include all the information that is pertinent to your case. Appeal decisions will be made within 30 days of the request and will be made in writing.

PERSONAL INFORMATION

I am applying for: Paratransit Eligibility Paratransit Eligibility Renewal

Gender Male Female

Name _____

Address _____

City _____ State _____ Zip _____

Mailing Address (if different from home address) _____

City _____ State _____ Zip _____

Telephone Number (Home) _____

Telephone Number (Work) _____

Date of Birth (MM/DD/YYYY) _____

Medicaid Recipient? Yes No Medicaid ID # _____

Email _____

Primary Language: English Spanish Sign Language

EMERGENCY CONTACT INFORMATION

(List at least one emergency contact)

Name _____

Relationship to Applicant _____

Telephone Number (Daytime) _____ (Alternate) _____

Is this person authorized to schedule trips on your behalf? Yes No

Name _____

Relationship to Applicant _____

Telephone Number (Daytime) _____ (Alternate) _____

Is this person authorized to schedule trips on your behalf? Yes No

PRESENT MEANS OF TRAVEL

1. Have you recently (within the last 3 months) used RMTD's accessible fixed-route service?

Yes No

If not, have you attempted to use an accessible fixed-route service within the last 3 months?

Yes No

If yes, please tell us about your experience _____

2. If you do not currently ride the accessible fixed-route service, what might help you do so?

- Route and schedule information
 - Training on how to travel on the bus
 - Having bus stops closer to where I live and need to go
 - Other (please explain) _____
-

How long have you lived in the RMTD community offering fixed route?

Under 1 year 1 to 3 years More than 3 years

3. What are your 3 most frequent travel destinations and how do you reach them currently?

Destination	Travel Frequency	Mode of Travel

4. Where is the nearest bus stop to your residence? Please give a location or intersection.

5. Select any obstacles you experience when traveling to the nearest bus stop:

- Busy street(s) to cross Lack of curb Road construction Excessive distance No sidewalks
- Poor sidewalk conditions Steep incline Steep decline Time of day

Other (please explain) _____

6. Do you use any of the following mobility aids while traveling?

Support cane Crutches Walker Oxygen Manual wheelchair Power wheelchair
 Scooter (3 wheel) Service animal White cane Other (please specify) _____

7. If you do not currently ride RMTD accessible fixed-route service, please select all the reasons that apply:

Not sure how to ride Bus stop is too far away There are no sidewalks where I live
 I am afraid to ride I do not want to ride The ground is too uneven/steep to get to the bus stop
 I need a wheelchair lift/ramp I am not able to recognize a destination or landmark
 I am able to use RMTD accessible fixed-route service under certain circumstances (please explain)

DISABILITY AND FUNCTIONAL LIMITATION INFORMATION

1. What type of disability prevents you from using the accessible fixed-route service? Please specify any disabilities that your medical professional is treating you for.

Physical Developmental Visual Hearing Cognitive Behavioral Other (please explain)

2. Do you require the services of a Personal Care Assistant when you travel? Yes No

Note: RMTD does not provide a Personal Care Assistant, and it is the responsibility of the client.

How would you classify your health condition or disability? Short Term/Temporary (up to 1 Year)
 Medium/Long Term (up to 3 Years) Permanent

Please select ALL disabilities that significantly affect your ability to access RMTD accessible fixed-route service:

Alzheimer's Disease Amputation Anxiety/Panic Attacks Arthritis Asthma Autism Spectrum Cancer (specify) _____ Cataracts Cerebral Palsy Congestive Heart Failure
 Chronic Obstructive/Pulmonary Disease (COPD) Cystic Fibrosis Dementia Diabetes (severe) Emphysema Epilepsy (severe) Heart Attack Traumatic Head Injury Kidney Disease/Dialysis Legally Blind Macular Degeneration Intellectual Disability Multiple Sclerosis Muscular Dystrophy Paraplegia Parkinson's Disease Peripheral Vascular Disease Quadriplegia
 Retinopathy Schizophrenia/Schizoaffective Disorder Stroke/Cerebral Trauma Systemic Lupus

Erythematosus Thrombosis (Chronic) Blindness Other (please specify) _____

DISABILITY AND FUNCTIONAL LIMITATION INFORMATION (CONTINUED)

Please describe how the disabilities that have been selected above significantly affect your ability to access accessible fixed-route service. We ask you to be as thorough and specific as possible.

3. Does your health condition or disability change from day-to-day in ways that would affect your ability to use RMTD accessible fixed-route service?

Yes No

If yes, please explain _____

4. Are you currently receiving any type of treatment or therapy related to your health condition or disability? Yes No

If yes, what is the expected duration? _____ Days _____ Months _____ Years Permanent

5. Are there any other aspects of your health condition or disability that we should know about?

Yes No

If yes, please explain _____

PROFESSIONAL RELEASE OF INFORMATION

In order to allow RMTD to evaluate your request for paratransit eligibility, it will be necessary for us to contact a physician or other professional to confirm the information that you have provided. **Please complete the following information and professional release authorization form and return it with your application.**

I, the applicant, understand that the purpose of this application is to determine my eligibility to use RMTD paratransit service. I hereby authorize my health care provider or other professional listed below to release information about my disability and its effect on my ability to travel, which may be needed in connection with my request for ADA paratransit eligibility certification.

Signed: _____ Date: _____

Printed name of Applicant: _____

If the applicant is a minor or has a legal guardian, the parent or guardian must sign this application and attest to the accuracy:

Signature of Parent or Legal Guardian: _____

Relationship: _____ Phone: _____ Date: _____

In the space below, CLEARLY PRINT the name of the Health Care Professional who will be verifying your application and his/her medical position.

Name of Professional: _____

Address/city/state/zip: _____

Phone: _____ Fax: _____

licensed physician certified psychologist nurse (LPN/RN)

vision specialist ophthalmologist mobility specialist

speech pathologist licensed physical therapist hearing specialist licensed social worker mental health counselor licensed occupational therapist certified rehabilitation specialist

I am applying for ADA paratransit service provided by RMTD. This service is limited to persons with disabilities that prevent them from utilizing accessible fixed-route services.

- I authorize the release of the information described below for the sole purpose of allowing RMTD to make a determination of my paratransit eligibility status.

Applicant Name (print) _____

Applicant Signature _____ Date _____

CERTIFICATION

I certify that the information I give in this application is true and correct. I understand that falsification of information may result in denial of service. I understand all information related to my disability will be kept confidential and only the information required to provide service will be disclosed to those who perform this service or related services.

Applicant Signature _____

Date _____

A. Person completing form if other than applicant (please check one):

I certify that the information provided in this application is true and correct, based upon the information given to me by the applicant.

I certify that the information provided in this application is true and correct, based upon my knowledge of the applicant's health condition or disability.

Name (person completing application on behalf of the client) _____

Signature _____

Date _____ Daytime Phone Number _____

Relationship to Applicant _____

Address _____

City _____ State _____ Zip _____