Concho Valley Transit District

Return to:
510 N. Chadbourne St.
P.O. Box 60050
San Angelo, TX 76906

ADA PARATRANSIT ELIGIBILITY CERTIFICATION FORM

ADA Paratransit is designed to serve only those persons whose severity of disability *prevents* them from using the Urban Fixed Route system. Concho Valley Transit (CVT) will use the information obtained during this certification process only for the provision of transportation services. CVT reserves the right to request additional information that may help to determine eligibility of the applicant for CVT ADA Paratransit services provided in San Angelo, TX.

CVT ADA Paratransit is a "curb-to-curb", shared ride system comparable to regular fixed route services. The cost per CVT ADA Paratransit trip is **$2 each way** ($4 round-trip), payable to each driver **in exact change**. Ten (10) trip punch cards are available for $20.

We do **NOT** provide same day service! **ALL appointments must be made before 3 P.M. the day BEFORE** the appointment. To be eligible, you must live within three-quarters (3/4) of a mile from a fixed route.

All CVT Paratransit eligibility determinations are based on the paratransit criteria and guidelines set forth in the Americans with Disabilities Act (ADA) of 1990.

The CVT ADA Paratransit eligibility process can take up to **21 days after receiving a completed application.** For CVT to better assess your needs and abilities, please take time to answer **ALL questions and fill in ALL blanks**. **Pages 1-6 need to be completed by you or someone that is assisting you. The last 2 pages (7 & 8) must be completed by your medical provider or certified/licensed caretaker who is familiar with your condition.** Applications that are not **legible** or **signed** by applicant **AND** medical provider/caretaker will be returned.

Personal and Contact Information

NAME _____
First MI Last

HOME ADDRESS _____
Street Apt # City State Zip

NAME OF APARTMENT COMPLEX (Bldg#/Letter) _____

MAILING ADDRESS _____
(If different from home address) Street Apt # City State Zip

Home Phone _____ Alternate contact number _____

Date of Birth ____/____/_____(Month/Day/Year)

EMERGENCY CONTACT _____

Name Relationship Phone Number

HOME ADDRESS _____

Street Apt # City State Zip

Do you currently have Medicaid? Yes ____ No ____

Current Transportation

Check which applies: _____ New Applicant _____ADA Paratransit Renewal (ADA #_____)

1. Do you use **Urban Fixed Route** buses now**?** Yes ____ No ____ Sometimes ____
If No or Sometimes, what prevents you from using Urban Fixed route buses? (i.e. no sidewalks)

_____

_____

2. What is the most **difficult** part of riding Urban Fixed Route buses for you?

_____

_____

3. Please tell us about the times when you **can** use the regular fixed route buses.

_____

_____

4. What is the **closest** bus stop to your residence? (Please list location)

_____

5. Can you get to this stop location by yourself? Yes ____ No ____ Sometimes ____
If No or Sometimes, explain: _____

_____

6. **Are you able to…**
Use a telephone to make calls/get information about bus service? Yes ____ No____
Ask for, understand, and follow written or spoken directions? Yes_____No_____

7. **Can you board a bus by yourself?**
(**Note**: persons who **do not** use wheelchair and **cannot** board the bus are permitted to enter the bus using the ramp and/or the lift)

Yes _____ (without lift/ramp) Yes_____ (using lift/ramp) No _____ Sometimes _____

If No or Sometimes, explain: _____

_____

8. If you **do not** ride the **Urban Fixed Route** buses: **how do you currently travel?** (i.e. family, friends, personal vehicle, cab) Please identify all modes available to you:

_____

9. In the past, have you used public transportation to travel?
Yes_____No____ If Yes, list location (city or state)_____

Mobility and Functional Ability

Mark all that are used regularly... put appropriate ✔ in box.

_____**Manual Wheelchair	_____ **Wide Wheelchair	_____Crutches
_____**Long Wheelchair	_____Stroller-Type Chair	_____Prosthetic(s)
_____**Electric Wheelchair	_____Walker (non-folding)	_____Cane/White
_____**High Wheelchair	_____Walker (folding)	_____Braces
_____**Power Scooter	_____Service Animal	_____ None of These
_____Portable Oxygen	_____Communication Device	_____Other

If Other, please describe:

_____

****If** you use a manual or powered wheelchair or scooter, is it more than 30" wide and more than 48" long? Yes _____ No _____

****If** you use a manual or powered wheelchair or scooter, what is the combined weight of occupant and device? _____

Note: The Americans with Disabilities Act (ADA) states that a transportation provider may decline to carry a mobility device/occupant if the combined weight exceeds that of the lift specifications set by the manufacturer, or if the carriage of the mobility device is demonstrated to be inconsistent with legitimate safety requirements.

1. Do you have a Personal Care Attendant (PCA): **A Personal Care Attendant is someone designated or employed specifically to help the eligible individual meet his or her personal needs.** Does your disability require that you travel with a PCA?
   Yes _____ No _____ Sometimes _____

2. If you have a disability affecting mobility, use the distance measure listed below and please indicate what distance you are able to travel **without the assistance** of another person:
   - _____ Less than 200 ft.
   - _____ 1 - 2 blocks
   - _____ 3 - 4 blocks
   - _____ 5 - 6 blocks
   - _____ 7- 8 blocks
   - _____ 9 or more blocks

3. Is your ability to **independently travel** this distance affected by **weather** such as snow, ice/temperature, or barriers such as steep hills, or other terrain?
   Yes _____ No _____If Yes, explain: _____

Mobility and Functional Ability Continued…

4. **Can you climb three (3) 10-inch steps, without assistance?** Yes ____ No ____ Sometimes ____
   If No or Sometimes, explain: _____

5. Are you able to **wait outside** in different weather conditions for 15–30 minutes?
   (**Note**: use of your normal mobility aid is okay) Yes ____ No ____ Sometimes _____
   If No or Sometimes, explain:_____

6. Are you able to cross traffic at a light-controlled intersection in the following areas?
   _____Residential _____Semi-Business _____Business

7. If you have a **cognitive disability**, are you able to:
   a. Give name, address, and telephone numbers upon request? Yes ____ No ____ Sometimes ____
   b. Recognize a destination or landmark? Yes ____No ____ Sometimes ____
   c. Deal with unexpected situations or changes in routine? Yes ____ No ____ Sometimes ____
   d. Ask for, understand, and follow directions? Yes ____ No ____ Sometimes ____
   e. Safely and effectively travel through crowded and/or complex facilities? Yes ____ No ____ Sometimes ____ If Sometimes, explain: _____
      _____

8. If you have a **speech or hearing impairment**, are you able to:
   a. Communicate with an augmentative device? Yes ____ No ____ Sometimes ____
   b. Communicate in writing? Yes ____ No ____ Sometimes ____
   c. Communicate over the telephone? Yes ____ No ____ Sometimes ____

9. Do you request provisions for **reasonable accommodation,** under **ADA** and **Section 504 guidelines**? Yes ____ No ____
   If Yes, explain your request for provisions: _____
   _____
   If Yes, please list common trip destinations and their contact information: _____
   _____
   _____

Neighborhood Environment

1. How would you describe the area where you live (i.e., very steep hill; long, gradual hill, flat, no sidewalks, etc.)? _____
   _____

   Are there sidewalks at your residence? Yes____No____
   Is there a ramp at your residence? Yes____ No____
   Is a ramp needed? Yes____ No____

2. Are there steps at the entrance to your residence? Yes_____ No_____
   If Yes, approximately how many steps? _____

3. Do you live on the ground floor? Yes_____ No____

4. **Is there an Urban Fixed Route bus that travels in your neighborhood?**
   Yes _____ No_____ Unknown_____

5. How do you currently get around in your neighborhood**?** (i.e. walk, walk using cane, wheelchair, etc.)_____
   _____

Medical/Disabling Condition

Please check the medical, health, or disabling condition(s) that ***prevents*** you from using the **Urban Fixed Route** services. List all conditions/disabilities that apply:

_____Paraplegic	_____Multiple Sclerosis	_____Stroke
_____Quadriplegic	_____Diabetes	_____Legally Blind
_____Intellectual Disability	_____Arthritis (hip, leg, other)	_____Epilepsy
_____Asthma	_____Alzheimer's	_____ Other

Please explain in detail:_____

_____

1. Please explain the severity/level/degree of disabling condition:_____
   _____

2. How does this disabling condition ***prevent*** you from using **Urban Fixed route** buses?_____
   _____

3. Is this condition/disability **temporary**? Yes _____ No _____
   If Yes, what is the expected duration: _____

4. Does your condition/disability change from day-to-day in ways that affect your ability to use **Urban Fixed Route** service? Yes _____ No _____ If yes, please explain:
   _____
   _____
   _____

5. Do you have a **Personal Care Attendant (PCA)?** A Personal Care Attendant is someone designated or employed specifically to help the eligible individual meet his or her personal needs. Yes _____ No _____ Sometimes _____
   If yes or sometimes, please explain: _____
   _____
   _____

6. **Is there any other medical information or effects of your disability that CVT should know in the event of an emergency?** (e.g. Hepatitis, Tuberculosis, Asthma, Diabetes)
   Please explain:_____
   _____
   _____
   _____

Please attach any supportive documentation from a medical provider or certified/licensed caretaker. Any additional comments are welcomed to help CVT assess and assist your needs for ADA Paratransit.

I certify that the information provided on this application is true and complete. I understand that any false information or omission may lead to termination of my transportation privileges on the ADA Paratransit vehicles. (*This form must have the original signature of the applicant before it will be accepted).*

Applicant's signature_____Date_____

If someone other than the person requesting certification has completed this application form, please complete the following:

Name_____
Address_____
Telephone Number_____
Relationship to Applicant_____

STOP! Response to the remaining questions on this application must be provided by a medical provider or certified/licensed caretaker who is familiar with your condition. DO NOT TAKE THE APPLICATION PAGES APART. Take the entire form to your provider so that the medical section may be completed and the complete form may be returned to CVT.

Thank you

Dear Provider:

<u>The Americans with Disabilities Act of 1990 (ADA)</u> requires CVT to provide paratransit service to individuals who, because of their medical condition or impairment, are prevented from using regular CVT Fixed Route bus service for most trips. Age, economic status, and environmental conditions may not be considered 'medical' factors in the assessment of paratransit eligibility. The information requested of you in the following sections will be used to determine the applicant's CVT ADA Paratransit eligibility. It is important that all questions be answered completely and accurately to the best of your knowledge and in accordance with your records. If the information is incomplete or unclear, we may need to contact you for clarification. Thank you for your cooperation.

1. Please indicate date of your **most recent** examination of this applicant: _____
2. Based on your knowledge of the patient's condition, is the information provided on the previous pages a reasonable representation of his/her condition? Yes _____ No _____
   If No, please explain: _____
   _____
3. How does the disability prevent the applicant from riding the regular fixed route system? What are their functional limitations? _____
   _____
4. **If cognitively impaired**, what is the most recently recorded IQ or Performance Test Scores and date of testing? _____
   _____
5. If temporary, what is a reasonably anticipated recovery date for independent travel?
   _____
6. Can applicant travel independently from his/her house, to the sidewalk? Yes _____ No _____
   If "no" or "sometimes", please explain: _____
   _____
7. Does the applicant's disability **require** him/her to travel with another person who provides personal assistance? Yes_____ No_____ Sometimes_____
8. Could the applicant benefit from travel training, if it was available? Yes_____ No_____
9. Is applicant wheelchair **dependent**? Yes _____ No _____
10. Can the applicant walk up and down three steps (10" rise, each step, with handrails available)? Yes_____ No_____ Sometimes_____
11. Does the applicant require a lift-equipped vehicle to board? Yes_____ No_____
12. Please list any other factors which significantly restrict the applicant's mobility:(i.e. extreme temperatures) _____
    _____

CERTIFICATION:

I hereby certify that the information I have provided in this application is a fair representation of this applicant's medical impairment or condition and is accurate to the best of my knowledge. I understand that the information provided here to will be used for the sole purpose of determining the applicant's eligibility for paratransit services. I, also, agree that CVT may contact me for clarification of any information I have provided and that I will reply in good faith.

Provider's Full Name:_____

Institution/Facility/Agency Name:_____

Street Address:_____ Suite# _____

City:_____ State: _____ Zip Code:_____

Medical License Number:_____ Telephone#_____ FAX#_____

Physician's Signature: _____

_____ Date: _____

*__Note__: "Stamped" signatures in the certification section will not be accepted