ADA Paratransit Eligibility Application and Instructions

Dear Applicant,

Thank you for inquiring about applying for Connect Transit's Paratransit service. Enclosed is a copy of an application for Certification for ADA Paratransit (Call -A-Ride) Eligibility.

Please read the enclosed materials carefully before completing the application.

Call-A-Ride is Connect Transit's shared-ride, origin-to-destination ADA service for individuals who are unable to use fixed stop bus route service due to the loss or lack of physical or mental functionality. The loss or lack of functionality to use fixed route service may include being unable to travel to and from bus stops, board or exit buses, or understand how to ride and use the bus system.

If you need assistance completing this form or have questions, please contact our office at 435-792-3122. This letter and application are available in different formats.

After you have completed your portion of the application information, please have a professional who is familiar with your functional abilities and limitations (whether physical, mental or both) complete the Professional Verification section. The information you provide in this application is protected as confidential personal information.

When a completed application is received, information will be reviewed for eligibility by the Connect Paratransit Eligibility Officer in accordance with the criteria outlined in 49 CFR part 37. Please be aware that disability, age, and/or distance to and from a bus stop DO NOT, by themselves, qualify a person for paratransit.

If an application for eligibility is denied, an appeal of the decision can be made. The request for appeal review must be submitted withing 60 days of notification of eligibility denial. Connect will provide an opportunity to be heard and to present information and arguments to an Appeals Committee within 30 days of receipt of the appeal. All requests must be submitted to the Paratransit Eligibility Office in writing to:

Connect Paratransit Eligibility Officer
3021 N 300 W
North Logan, UT 84341
Email: eligibility@rideconnectutah.gov

Instructions For Applicants

1. *Please **PRINT OR TYPE full responses to all of the questions** on the application form. Your detailed responses and explanations will help us make an appropriate determination. Be sure to **respond to ALL questions or your application will be considered incomplete**. Incomplete applications will be **returned**.*

2. ***The Applicant Certification page must be completed and properly signed to complete the application**:*
    a. *Applicant Certification (Page 7)*

3. *YOU ARE REQUIRED TO PROVIDE ONE FULLY COMPLETED PROFESSIONAL VERIFICATION WITH YOUR APPLICATION. Your application will be considered incomplete without this. We have provided you with the form that is required to be completed by a professional that is familiar with your functional abilities. Additional professional verifications are not required but may be submitted, if desired, using copies of the form provided.*

For help with the application process or to check on the status of your application call 435-792-3122

ADA Paratransit Eligibility Application

A. INFORMATION

Name: _____ ☐ Female ☐ Male
First Middle Initial Last

Home address: _____ Apt #: _____

City/State: _____ Zip: _____

Mailing address: _____ Apt #: _____

City: _____ Zip: _____

Telephone: (____) _____ Date of Birth: ____/____/____

Email address: _____

B. ADDITIONAL CONTACT (REGARDING PERSONAL INFORMATION)

If you would like someone else to be able to answer questions about your application, please fill out the contact information below. Otherwise mark N/A.

☐ **N/A** Name: _____

Telephone: (____) _____ Email address: _____

C. LOCAL EMERGENCY CONTACT

Please provide the name of a LOCAL friend or relative to call in the event of an emergency:

Name: _____
First Middle Initial Last

Home address: _____ Apt #: _____

City/State: _____ Zip: _____

Telephone: (____) _____ Relationship: _____

D. TELL US ABOUT YOUR CONDITION THAT LIMITS YOUR FUNCTIONAL ABILITY

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

1. Describe the physical, mental or other health **condition(s) that PREVENT** you from using regular public transit without the help of another person?

_____

_____

_____

_____

2. Briefly explain **HOW** your condition(s) prevents you from using regular public transit without the help of another person.

_____

_____

_____

_____

_____

_____

3. Are the condition(s) you described:

☐ Permanent ☐ Temporary ☐ Don't Know

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

_____

E. TELL US ABOUT YOUR CAPABILITIES AND USUAL ACTIVITIES

4. Do you use any of the following mobility aids or specialized equipment? *(Check all that apply):*

- ☐ Cane
- ☐ Power Wheelchair
- ☐ Communication Devices
- ☐ White Cane
- ☐ Other Aid _____
- ☐ Service Animal
- ☐ Walker
- ☐ Power Scooter
- ☐ Crutches
- ☐ Manual Wheelchair
- ☐ Leg Braces
- ☐ Portable Oxygen Tank

5. Please check the box that best describes your current living situation:

- ☐ 24-hour care or Skilled Nursing Facility
- ☐ Assisted Living Facility
- ☐ I receive assistance from someone that comes to my home to help with daily living activities
- ☐ I live with family members who help me
- ☐ I live independently (without the assistance of another person)

6. How many city blocks can you travel with your usual mobility aid and without the help of another person?

_____

7. Which of the following statements best describes you if you had to wait outside for a ride? *(Check only one response):*

- ☐ I could wait by myself for ten to fifteen minutes
- ☐ I could wait by myself for ten to fifteen minutes only if I had a seat and shelter
- ☐ I would need someone to wait with me because _____

_____

8. Which of the following statements best describes you? *(Check only one response):*

- ☐ I have never used regular public transit
- ☐ I have used regular public transit but not since the onset of my disability
- ☐ I have used regular public transit within the last six months

F. TELL US ABOUT YOUR TRAVEL NEEDS

9. How do you currently travel to your frequent destinations? (*Check all that apply*):

☐ Buses ☐ Drive myself
☐ Paratransit ☐ Someone drives me
☐ Other _____

10. Do you travel with the help of another person?

☐ Always ☐ Sometimes ☐ Never

a. If "**always**" or "**sometimes**," what type of help do they provide?

_____

11. Would you be able to get to and from the public transit stop nearest your home?

☐ Yes ☐ No ☐ Sometimes

a. If "**no**" or "**sometimes**," explain why:

_____

12. Would you be able to maintain balance and tolerate movement of a public transit vehicle when seated?

☐ Yes ☐ No ☐ Sometimes ☐ Don't know, never tried it

a. If "**no**" or "**sometimes**," explain why:

_____

Applicant Certification

I **certify** that the information in this application is **true** and **correct**. I understand that knowingly falsifying the information will result in denial of service. I understand all information will be kept confidential, and only the information required to provide the services I request will be disclosed to those who perform the services.

I understand that it may be necessary to contact a professional familiar with my functional abilities to use public transit in order to assist in the determination of eligibility.

Applicant's signature: _____ Date: _____

If this application is being completed by someone other than the applicant requesting certification, that person must complete the following:

Name:_____Relationship:_____

Address:_____

Telephone: (Day)_____(Evening)_____

Please check one of the items below:

- ☐ I certify that the information provided in this application is true and correct based upon information given to me by the applicant.
- ☐ I certify that the information provided in this application is true and correct, based upon my own knowledge of the applicant's health condition or disability.

Signature: _____ Date: _____

Please Note: It is your responsibility to notify us if your functional ability improves enough to change your eligibility status. If your condition improves after you have been determined eligible or we discover you submitted false information, your eligibility could be suspended, or you may be asked to re-apply.

Professional Verification

This part of the application form should be completed by a health care professional **who is currently treating the applicant for their functional disability and** is authorized to provide this information to Connect Transit.

The individual who has asked you to review and sign this application is applying to the Connect Transit Program to be considered eligible for paratransit service. **ADA paratransit service is intended ONLY for those trips that the person cannot take on the regular public bus fixed route system due to his/her limited or reduced physical or mental functional ability**. All information will be kept confidential.

Failure to complete this form could result in denial of service for the applicant. Please print clearly.

Applicant Name:_____

1. What is your professional relationship (doctor, therapist, etc.) to the applicant and for how long?

   _____

2. Please indicate the medical diagnoses that impact the applicant's functional ability to use public transportation (regular bus services).

   _____

   _____

   _____

   _____

3. If the disability is cognitive or developmental, please supply information regarding the applicant's condition that affects their functional abilities.

   _____

   _____

   _____

4. Is the condition temporary? ☐ Yes ☐ No

   a. If **yes**, please specify the time when you anticipate the applicant to recover, or next reevaluation.

   _____

5. How does the diagnosed disability prevent travel on ADA accessible fixed-route buses?

   _____

   _____

6. Does the applicant require use of the following? (*Check all that apply*)

- ☐ Manual wheelchair
- ☐ Motorized wheelchair
- ☐ Cane, Crutches, or Walker
- ☐ Service Animal
- ☐ Personal care attendant

7. Is the applicant able to do any of the following with the use of a mobility aid and without the assistance of another person? (*Check all that apply*)

- ☐ Travel ½ block
- ☐ Travel 1 block
- ☐ Travel 2 blocks
- ☐ Travel 4 blocks or more
- ☐ Climb three 12" steps

a. If **any of the above weren't checked**, describe the factors which limit the applicant's functional abilities to travel:

_____

_____

8. Can the applicant independently cross the street? ☐ Yes ☐ No

9. Does weather impact the applicant's ability to ambulate? ☐ Yes ☐ No

a. If **yes**, please explain and list the temperatures at which the applicant would be impacted.

_____

_____

10. Please note any additional information you feel is relevant about the applicant's functional ability to travel on ADA accessible fixed-route buses.

_____

_____

I certify under penalty of perjury that I am the person completing this application and that all information provided is true, accurate, and complete to the best of my knowledge.

Signature_____Date:_____

Print Name_____

Daytime Phone Number:_____Agency/Clinic: _____

Address:_____

Professional License, Registration or Certification #: _____Expires:_____