Concho Valley Transit District

Return to:
2801 W. Loop 306 Suite A
San Angelo, TX 76904

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. The CVTD-Concho Valley Transit District will only use the information obtained during this certification process for the provision of transportation services. CVTD reserves the right to request additional information that may help to determine eligibility of the applicant for CVTD ADA Paratransit services provided in San Angelo, TX. CVTD ADA Paratransit is a "curb-to-curb", shared ride system comparable to regular fixed route services. The cost per CVTD ADA Paratransit trip is **$2 each way** ($2 to each destination) payable to each driver in exact change. Ten (10) trip punch cards are available for $20. We do **NOT** provide same day service and all appointments must be made **before 3pm the day prior** to the appointment. To be eligible, you must live within three-quarters (3/4) of a mile from a fixed route.

All CVTD Paratransit eligibility determinations are based on the paratransit criteria and guidelines set forth in the **Americans with Disabilities Act (ADA) of 1990.** The CVTD ADA Paratransit eligibility process can take up to **21 days after we have received you completed application.** For CVTD to better assess your needs and abilities please take time to answer **ALL questions and fill in ALL blanks**, applications that are not **legible** or are not signed by applicant will be returned.

Personal and Contact Information

NAME_____
First MI Last

HOME ADDRESS _____
Street Apt # City State Zip

NAME OF APARTMENT COMPLEX (Bldg#/Letter): _____

Home Phone _____ Alternate contact number_____

Mailing address _____

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

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

Emergency Contact Information

NAME_____
Relationship Phone Number

ADDRESS_____
Street Apt # City State ZIP

Current Transportation

Are you a: ☐ **ADA Paratransit Renewal (ADA #_____)** ☐ **New Applicant**

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 give 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?** (Please note: persons who do not use wheelchair **but** who cannot board the bus are permitted to enter the bus by using the ramp and/or the lift)

   Yes ___ (w/out 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 as a means to conduct travel?

Yes_____No____ If Yes, where (city or state) _____

_____

Mobility and Functional Ability

(Mark all that are used regularly… put appropriate ✔ in box)

****Manual Wheelchair**	☐	****Electric Wheelchair**	☐	****Power Scooter**	☐
****Long Wheelchair**	☐	****High Wheelchair**	☐	****Wide Wheelchair**	☐
Stroller-Type Chair	☐	**Walker (non-foldable)**	☐	**Walker (Foldable)**	☐
Cane/White	☐	**Crutches**	☐	**Braces**	☐
Service Animal	☐	**Prosthetics**	☐	**None of these**	☐

****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 ADA (Americans with Disabilities Act) 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.

Please answer Yes or No…

Use of:

Portable Oxygen	☐	**Communication Device**	☐	**None of These**	☐

Other
(Please describe) ☐

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 applicant has 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	_____ 5 - 6 blocks
_____ 1 - 2 blocks	_____ 7- 8 blocks
_____ 3 - 4 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): _____
4. **Can you climb three 10 inch steps without assistance?** Yes _____ No _____ Sometimes _____
   If No or Sometimes explain): _____

Mobility and Functional Ability Continued…

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?
   b. Recognize a destination or landmark?
   c. Deal with unexpected situations or unexpected changes in routine?
   d. Ask for, understand and follow directions?
   e. Safely and effectively travel through crowded and/or complex facilities?

   Yes _____ NO _____ Sometimes _____ N/A_____

   If Sometimes(explain): _____
   _____
8. If you have a **speech impairment**, are you able to:
   a. Communicate with an augmentative device?
   b. Communicate in writing?
   c. Communicate over the telephone?

   Yes _____ NO _____ Sometimes _____ N/A_____

   Sometimes(explain): _____
   _____

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 one needed? Yes_____No___
2. How many steps are there at the entrance to your residence? _____
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 ***prevent*** you from using Urban Fixed route services. List all conditions/disabilities that apply:

_____ Paraplegic	_____Multiple Sclerosis	_____Stroke
_____Quadriplegic	_____Diabetes	_____Legally Blind
_____Mental Retardation	_____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, expected duration--until: _____
   Ending Date of 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 CVTD should know in the event of an emergency?** (e.g. Hepatitis, Tuberculosis, Asthma)
   Explain:_____

   _____

   _____

Please attach any supportive documentation from a medical provider or certified/licensed caretaker. Any additional comments are welcomed here to help CVTD assess your need for ADA Paratransit (optional):_____

_____

_____

_____

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 CVTD.

Thank you

Dear Provider:

<u>The Americans with Disabilities Act of 1990</u> requires CVTD to provide paratransit service to individuals who, because of their medical condition or impairment, are prevented from using regular CVTD 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 CVTD 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 ___ Maybe ____
9. Is applicant wheelchair **dependent**? Yes _____ No _____
10. Can the applicant walk up and down two 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 (i.e. extreme temperatures) which significantly restrict the applicant's mobility: _____
    _____

CERTIFICATION:

I certify that the information I have provided here to 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 CVTD 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.