CONCHO VALLEY TRANSIT DISTRICT
ADA PARATRANSIT PROGRAM

Program Information:

The Concho Valley Transit District (CVTD) provides ADA Paratransit service to ensure accessible transportation for individuals with disabilities who cannot independently use the Fixed Route bus system. This specialized service operates in accordance with the Americans with Disabilities Act (ADA) of 1990 and is available only to residents living within the San Angelo city limits.

ADA Paratransit is a **shared, destination-to-destination service** (based on available pickup locations) that operates during the same hours and days as CVTD's Fixed Route buses.

This program provides essential access to medical, nutritional, employment, and other quality-of-life destinations for those unable to utilize CVTD's Fixed Route system.

Program Eligibility and Conditions:

Client Eligibility: Service is available only to individuals with disabilities who are unable to independently navigate or use Fixed Route transportation.

Application Process: ADA Paratransit Program application must be filled out completely and accurately, and signed by the client or guardian and someone with a professional accreditation, before services can begin.

To apply for ADA Paratransit services, you can access the application in three ways:

1. **In Person:** Pick up and drop off applications at the Multi-Modal Facility, Monday – Friday, 8:00 AM to 5:00 PM.
2. **By Mail:** Request an application by calling 325-947-8729. Completed applications should be mailed back and marked "confidential" on the envelope to protect your privacy.
3. **Online:** You can download the application from the CVT website at www.cvtd.org under the programs tab. Completed applications must be submitted in person or by mail.

Please mail your completed application to;
Concho Valley Transit District
ATTN: Compliance
510 N. Chadbourne Street
San Angelo, Texas 76903

Trip Eligibility: ADA Paratransit is available for all quality-of-life trips, such as medical (non-Medicaid), nutrition, employment, and community services.

Mobility Management – Travel Training:

CVTD offers Mobility Management Travel Training to our passengers become confident, independent transit riders. This free service is designed to ensure clients are comfortable using CVTD's transportation options safely and effectively.

Training Includes:

- Step-by-step assistance with completing required applications
- How to properly schedule and plan rides
- Boarding and exiting vehicles safely, including the use of mobility devices
- Understanding passenger responsibilities and the Code of Conduct
- Tips for traveling independently to medical, nutrition, employment, and community service destinations

How to Utilize and Arrange Transportation:

Scheduling a Trip: To arrange transportation, call **Concho Valley Transit District (CVTD) at 325-947-8729**. All trips must be scheduled by 3 PM the day before travel; same-day requests are not permitted.

Information Required: When scheduling, clients must provide their name, pick-up and drop-off addresses, trip purpose, and requested time. Return trips should be scheduled at the same time as the original booking.

Pick-Up Procedures: Riders should be ready at their designated pick-up location **15 minutes before** the scheduled time. Drivers will wait up to 5 minutes upon arrival before proceeding to the next stop.

Accessibility: All CVTD vehicles are **ADA accessible** and equipped to accommodate mobility devices.

Fare: $2 each way ($4 round-trip). Pay in exact change, through the Token Transit app, or with a $20 "Red Dot" punch card (suitable for 10 trips).

Concho Valley Transit District

ADA PARATRANSIT ELIGIBILITY CERTIFICATION PACKET

DATE: _____

PERSONAL AND CONTRACT INFORMATION

NAME: _____
FIRST MI LAST

DATE OF BIRTH: _____/ _____/_____ **(MONTH/DAY/YEAR)**

HOME ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIPCODE:** _____

☐ **CHECK IF MAILING ADDRESS IS THE SAME AS HOME ADDRESS**

MAILING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIPCODE:** _____

EMERGENCY CONTACT: _____
NAME RELATIONSHIP PHONE NUMBER

ARE YOU ENROLLED IN? MEDICAID - YES ☐ **NO** ☐

CHECK WHICH APPLIES: **NEW ADA APPLICANT** ☐ **ADA APPLICANT RENEWAL** ☐

CURRENT TRANSPORTATION

1. DO YOU USE FIXED ROUTE BUSES NOW? YES ☐ **NO** ☐ **SOMETIMES** ☐
IF NO OR SOMETIMES, WHAT PREVENTS YOU FROM USING FIXED ROUTE BUSES?

_____

_____

2. WHAT IS THE MOST <u>DIFFICULT</u> PART OF RIDING FIXED ROUTE BUSES FOR YOU?

_____

_____

3. IS THERE A TIME WHEN YOU CAN USE FIXED ROUTE BUSES?

_____

_____

4. WHAT IS THE CLOSET FIXED ROUTE STOP TO YOUR RESIDENCE?

_____

5. CAN YOU GET TO THIS LOCATION BY YOURSELF? YES ☐ NO ☐ SOMETIMES ☐
IF NO OR SOMETIMES, EXPLAIN:

_____

_____

6. IF YOU DO NOT CURRENTLY RIDE ADA PARATRANSIT OR FIXED ROUTE BUSES, HOW DO YOU CURRENTLY TRAVEL? (FAMILY, FRIENDS, PERSONAL VEHICLE, CAB, ETC.)

_____

7. HAVE YOU USED PUBLIC TRANSPORTATION IN THE PAST? YES ☐ NO ☐

MOBILITY AND FUNCTIONAL ABILITY

1. CAN YOU BOARD A BUS BY YOURSELF? YES ☐ NO ☐ SOMETIMES ☐
IF NO OR SOMETIMES, EXPLAIN:

_____

2. ARE YOU ABLE TO USE A TELEPHONE TO MAKE CALLS/GET INFORMATION ABOUT BUS SERVICES?
YES ☐ NO ☐

3. ARE YOU ABLE TO ASK FOR, UNDERSTAND, AND FOLLOW WRITTEN OR SPOKEN INSTRUCTIONS?
YES ☐ NO ☐

CHECK ALL THAT APPLY:

☐ MANUAL WHEELCHAIR	☐ ELECTRIC WHEELCHAIR	☐ POWER SCOOTER	☐ LONG WHEELCHAIR
☐ HIGH WHEELCHAIR	☐ WIDE WHEELCHAIR	☐ CRUTCHES	☐ STROLLER-TYPE CHAIR
☐ WALKER (FOLDABLE)	☐ CANE/WHITE	☐ BRACES	☐ WALKER (NON-FOLDABLE)
☐ SERVICE ANIMAL	☐ PROSTHETICS	☐ NONE OF THESE	

4. IF YOU USE A MANUAL OR POWERED WHEELCAHIR OR SCOOTER, IS IT MORE THAN 30" WIDE AND MORE THAN 48" LONG? YES ☐ NO ☐

5. IF YOU USE A MANUAL OR POWERED WHEELCHAIR OR SCOOTER, WHAT IS THE COMBINED WEIGHT OF THE OCCUPANT AND DEVICE? _____

6. IF YOU HAVE A DISABILITY AFFECTING MOBILITY, PLEASE INDIATE WHAT DISTANCE YOU ARE ABLE TO TRAVEL WITHOUT ASSISTANCE OF ANOTHER PERSON:

____ LESS THAN 200FT **____ 5 – 6 BLOCKS**

____ 1 – 2 BLOCKS **____ 7 – 8 BLOCKS**

____ 3 – 4 BLOCKS **____ 9 MORE BLOCKS**

____ N/A

7. IS YOUR ABILITY TO INDEPENDENTLY TRAVEL THIS DISTANCE AFFECTED BY WEATHER SUCH AS SNOW, ICE/TEMPATURE, OR BARRIERS SUCH AS STEEP HILLS, OR OTHER TERRAIN?
YES ☐ NO ☐
IF YES, EXPLAIN: _____

8. ARE YOU ABLE TO WAIT OUTSIDE IN DIFFERENT WEATHER CONDITIONS FOR 15 – 30 MINUTES?
YES ☐ NO ☐ SOMETIMES ☐
IF NO OR SOMETIMES, EXPLAIN:
_____

9. DO YOU HAVE A COGNITIVE DISABILITY? YES ☐ NO ☐
IF NO, PLEASE MOVE TO QUESTION 10.
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 FACILITIES? YES ☐ NO ☐ SOMETIMES ☐**

10. DO YOU HAVE A SPEECH OR HEARING IMPAIREMENT? YES ☐ NO ☐
IF NO, PLEASE MOVE TO QUESTION 11.
ARE YOU ABLE TO:

- **A. COMMUNICATE WITH AN AUGEMNTATIVE DEVICE? YES ☐ NO ☐ SOMETIMES ☐**
- **B. COMMUNICATE IN WRITNG? YES ☐ NO ☐ SOMETIMES ☐**
- **C. COMMUNICATE OVER THE TELEPHONE? YES ☐ NO ☐ SOMETIMES ☐**

11. DO YOU REQUEST PROVISIONS FOR RESONABLE ACCOMODATIONS, UNDER ADA AND SECTION 504 GUIDELINES?
YES ☐ NO ☐
IF YES, EXPLAIN YOUR REQUEST?
_____

NEIGHBORHOOD ENVIORNMENT

1. HOW WOULD YOU DESCRIBE THE AREA WHERE YOU LIVE? (VERY STEEP HILL, LONG GRADUAL HILL, FLAT, NO SIDEWALKS, ETC.) _____
_____

2. ARE THERE SIDEWALKS AT YOUR RESIDENCE? YES ☐ NO ☐

3. IS THERE A RAMP AT YOUR RESIDENCE? YES ☐ NO ☐

4. IS A RAMP NEEDED? YES ☐ NO ☐

5. ARE THERE STEPS AT THE ENTERANCE TO YOUR RESIDENCE? YES ☐ NO ☐

IF YES, HOW MANY? _____

6. DO YOU LIVE ON THE GROUND FLOOR? YES ☐ NO ☐

MEDICAL/DISABLING CONDITION

CHECK/LIST ALL CONDITIONS AND DISABILITIES THAT APPLY:

☐ **PARAPLEGIC**	☐ **MULTIPLE SCLEROSIS**	☐ **STROKE**	☐ **QUADRIPLEGIC**
☐ **DIABETES**	☐ **LEGALLY BLIND**	☐ **ARTHRITIS**	☐ **INTELLECTUAL DISABILITY**
☐ **EPILEPSY**	☐ **ASTHMA**	☐ **ALZHEIMER'S/DEMENTIA**	
☐ **OTHER**			

IF OTHER, EXPLAIN:

_____

_____

1. EXPLAIN THE SEVERITY/LEVEL/DEGREE OF DISABLING CONDITION:

_____

_____

2. IS THIS CONDITION/DISABILITY TEMPORARY? YES ☐ NO ☐

IF YES, EXPECTED DURATION: _____

3. DO YOU HAVE A PERSONAL CARE ATTENDANT (PCA)? YES ☐ NO ☐

4. HOW DOES THIS DISABILITY/CONDITION(S) PREVENT YOU FROM USING FIXED ROUTE BUSES?

_____

5. DOES YOUR DISABILITY/CONDITION(S) CHANGE FROM DAY-TO-DAY IN WAS THAT AFFECT YOUR ABILITY TO USE FIXED ROUTE BUSES? YES ☐ NO ☐

IF YES, 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, DIABETES, ETC.)

_____

_____

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 CVTD ADA PARATRANSIT PROGRAM.
(THIS FORM MUST HAVE THE ORIGINAL SIGNATURE OF THE APPLICANT/GUARDIAN BEFORE IT WILL BE ACCEPTED)

APPLICANT SIGNATURE: _____ DATE: _____

IF SOMEONE OTHER THAN THE PERSON REQUESTING CERTIFICATION HAS COMPLETED THIS APPLICATION, PLEASE COMPLETE THE FOLLOWING:

NAME: _____
ADDRESS: _____
TELEPHONE NUMBER: _____
RELATIONSHIP TO APPLICANT: _____

STOP! RESPONSE TO THE REMAINING QUESTIONS ON THIS APPLICATION MUST BE PROVIDED BY AN INDIVIDUAL WITH A PROFESSIONAL CERTIFICATION (MEDICAL PROVIDER, CARETAKER, SOCIAL WORKER, CASE MANAGER, MOBILITY MANAGEMENT STAFF, ETC.) WHO IS FAMILIAR WITH YOUR CONDITION. PLEASE DO NOT TAKE THE APPLICATION PAGES APART.

TO WHOM IT MAY CONCERN,

THE AMERICANS WITH DISABILITIES ACT OF 1990 (ADA) REQUIRES CVTD TO PROVIDE PARATRANSIT SERVICE TO INDIVIDUALS WHO, BECAUSE OF THEIR MEDICAL CONDITION OR DISABILITY, ARE PREVENTED FROM USING CVTD FIXED ROUTE BUS SERVICE FOR MOST TRIPS. AGE, ECONOMIC STATUS, AND ENVIRONMENTAL CONDITIONS MAY NOT BE CONSIDERED "MEDICAL/DISABILITY" 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 INTERACTION OF THIS APPLICANT: _____

2. BASED ON YOUR KNOWLEDGE OF THE CLIENT'S CONDTION, IS THE INFORMATION PROVIDED ON THE PREVIOUS PAGES A RESONABLE REPRESENTATION OF THEIR CONDITION? YES ☐ NO ☐
IF NO, EXPLAIN: _____

3. HOW DOES THE DISABILITY/CONDITION PREVENT THE APPLICANT FROM RIDING THE FIXED ROUTE SYSTEM? WHAT ARE THE LIMITATIONS?

_____
_____

4. IF TEMPORARY, WHAT IS THE ANTICIPATED RECOVERY DATE FOR INDEPENDENT TRAVEL? IF THIS IS NOT TEMPORARY, PLEASE MOVE ON TO QUESTION NUMBER 5.

_____

5. CAN THE APPLICANT TRAVEL INDEPENDENTLY FROM THEIR HOUSE TO THE SIDEWALK? YES ☐ NO ☐
IF NO, EXPLAIN: _____

6. CAN THE APPLICANT REQUIRE THEM TO TRAVEL WITH A PERSONAL CARE ATTENDANT?
YES ☐ NO ☐ SOMETIMES ☐

7. COULD THE APPLICANT BENEFIT FROM TRAVEL TRAINING? YES ☐ NO ☐

8. IS THE APPLICANT MOBILITY DEVICE DEPENDENT? YES ☐ NO ☐

9. PLEASE LIST ANY OTHER FACTORS WHICH SIGNIFICANTLY RESTRICT THE APPLICANT'S MOBILITY (EXTREME TEMPERTURES, ETC.)

_____
_____

CERTIFICATION:

I HEREBY CERTIFY THAT THE INFORMATION I HAVE PROVIDED IN THIS APPLICATION IS A FAIR REPRESENTATION OF THIS APPLICANT'S MEDICAL DISABILITY OR CONDITION AND IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THE INFORMATION PROVIDED HERE 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.

FULL NAME: _____
BUSINESS/AGENCY NAME: _____
STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
TELEPHONE: _____
SIGNATURE: _____
DATE: _____

***STAMPED SIGNATURES ON THIS CERTIFICATION WILL NOT BE ACCEPTED.**