Regional Transit

Accessible Services
1221 R Street
Sacramento, CA 95811
PHONE: 916-557-4685 or 916-557-4686 (TDD)
FAX: 916-455-3924
paratransit@sacrt.com
www.sacrt.com/accessibleservices.stm

Thank you for inquiring about eligibility for ADA Paratransit Service. Sacramento Regional Transit's Paratransit Service is a "Safety Net" for people with physical, cognitive or visual disabilities that are functionally unable to independently use the RT fixed route service either all of the time, temporarily or only under certain circumstances. Enclosed are the ADA Paratransit Application and Eligibility Brochure that explains ADA Paratransit Service. Please read the Eligibility Brochure carefully before completing your application.

The Steps in the Eligibility Process

1. Request the application packet.
2. Read the Eligibility Brochure that is enclosed.
3. Complete all questions on the Paratransit Application that follows this page.
4. Submit your application to your physician, or other professional, to complete the professional verification section.
5. Mail your signed and completed application and professional verification form to:
   Sacramento Regional Transit District, Accessible Services
   PO Box 2110
   Sacramento, CA 95812-2110
6. You may be asked to attend an in-person interview. Your eligibility will be determined within 21 days from the date you complete your telephone and/or in-person interview and functional assessment. You will be notified by letter as to your eligibility status.
7. If you do not receive written notice of RT's decision within 21 days, you may request paratransit services until a decision has been made by calling (916) 557-4685 or (916) 557-4686 (TDD).

An incomplete application will be returned and will delay processing.

EVERY QUESTION MUST BE ANSWERED AND LEGIBLE.

Revised August 2013

Application for ADA Paratransit Eligibility

Please complete **ALL** sections of this form. An incomplete application will be returned. The information you provide will help determine what type of transportation service is the right service for you. **All information will remain confidential.**

APPLICANT INFORMATION (PLEASE PRINT)

First Name_____ Middle Initial_____

Last Name_____

Mailing Address_____ Apt#_____

City_____ State_____ Zip_____ County_____

Home Address _____
(if different from mailing address)

Name of Facility/Apartment Building_____Gate Code:_____
(if applicable) *(if applicable)*

City_____ State_____ Zip_____ County_____

Phone (daytime) _____ (evening) _____

Cellular #_____ TTY for hearing impaired_____
(if applicable)

Email address *(if available)*_____

Date of Birth _____/_____/_____ SSN_____ Sex: ❒ Male ❒ Female
Month Day Year Last 4 Digits (only)

❒ **New Application** or ❒ **Recertification**

Please send me written information in an alternate format.

❒Large Print ❒Audio Tape ❒Braille ❒CD ❒Other:_____

❒ Español ❒ 中文 ❒ Русский ❒ tiêng Việt ❒Hmoob

Please provide the name of a LOCAL relative/friend in case of an emergency:

Name_____ Relationship_____

Phone (daytime) _____ (evening) _____

FOR STAFF USE ONLY

Date Received _____ Initials _____
Date Returned _____ Initials _____
Application Date Complete/Distributed _____ Initals _____

How do you travel now? Please check all that apply to you.

❒ walk ❒ drive a car ❒ ride in someone's car ❒ taxi ❒ bicycle

❒ paratransit ❒ RT bus ❒ RT light rail train Other:_____

List your common trips and the places you most often travel to in the spaces indicated below. Please refer to the following as an example:

Trip destination:

Building Location / Name ***UC Davis Medical Group, Internal Medicine – Dr. Smith***

2825 J Street, Suite 300 ***Sacramento*** ***95816***

Number and Street City ZIP Code

A. Trip destination:

Building Location / Name _____

_____

Number and Street City ZIP Code

B. Trip destination:

Building Location / Name _____

_____

Number and Street City ZIP Code

C. Trip destination:

Building Location / Name _____

Number and Street City ZIP Code

Do you have a cognitive or physical disability that, some or all of the time, causes you to be unable to get on, ride or get off the fixed-route buses or light rail trains by yourself, without the help of another person? ❒ Yes(If yes, explain) ❒ No:

_____

_____

What types of disabilities cause you to be unable to use RT's buses or trains?

❒ physical disability ❒ visual impairment/blindness ❒ developmental disability

❒ mental illness ❒ recent surgery ❒ other_____

When was your disability diagnosed? _____
Month/Year

Is your disability considered Stable? ❒ Yes ❒ No

Is your disability considered Progressive? ❒ Yes ❒ No

Is your disability temporary?

❒ Yes, I expect it to last _____months.
❒ No, it is permanent ❒ I don't know.

Paratransit Operators are unable to perform the duties of a Personal Care Attendant (PCA). Will you need to travel with a PCA or someone to assist you when you use paratransit?

❒ Yes; sometimes ❒ Yes; always ❒ No

If always or sometimes, how does a PCA or other person assist you?

Can you wait for a regular RT bus or light rail train?

❒ Yes ❒ Only if there is a bench or shelter
❒ No more than 15 minutes ❒ No

Can you maintain balance while seated on a moving vehicle?

❒ Yes ❒ No

How far can you walk on level ground?

❒ Less than 1 block ❒ 1 block ❒ 2 blocks ❒ 3 or more blocks

How far can you go on level ground with your mobility aid, if you use any?

❒ Less than 1 block ❒ 1 block ❒ 2 blocks ❒ 3 or more blocks

MOBILITY AID AND/OR EQUIPMENT INFORMATION

If you use a power wheelchair, or scooter, RT will need to verify what you and your wheelchair weigh together. Many power wheelchairs and scooters are very heavy. (RT paratransit vehicle lifts are designed to lift 600 to 800 pounds, depending on the paratransit vehicle type.)

Which of these mobility aids do you currently use when traveling? Please check all that apply to you. Do not select a device that you are waiting on for approval or prescription.

❒ white cane	❒ powered wheelchair *	❒ walker
❒ support cane	❒ powered scooter/cart *	❒ walker with seat
❒ crutches	❒ manual wheelchair *	❒ portable oxygen
❒ leg brace	❒ power assist wheelchair	❒ prosthesis
❒ service animal	❒ communication board	❒ no mobility aid

❒ other *(please specify)*_____

***** "Wheelchair" means a three or more wheeled mobility device.

If you checked manual wheelchair, power wheelchair, or powered scooter/cart, please provide the following information:

Is your mobility device oversized? ❒ Yes ❒ No

Does your mobility device weigh more than 600 pounds when occupied?

❒ Yes ❒ No

Do you know how much you and your wheelchair weigh together?

❒ Yes ❒ No

If yes, please provide the total weight: _____lbs.

What is the make/model of your wheelchair or scooter?

Make _____ Model _____

What is the width of your wheelchair or scooter? _____inches (if available)

What is the length of your wheelchair or scooter? _____inches (if available)

CURRENT USE OF RT'S FIXED-ROUTE BUSES AND LIGHT RAIL TRAINS

Do you use RT's fixed-route buses and/or light rail trains by yourself?

❒ Yes ❒ No

*If yes, how often?*_____ *Which routes do you use?*_____

When was the last time you used RT's fixed-route by yourself?_____

Do you need someone to travel with you when you travel in the community or when you use the accessible fixed-route buses or light rail trains?

❒ Yes; sometimes ❒ Yes; always ❒ No

Have you ever had training on how to travel around the community or how to use RT's accessible fixed-route buses or light rail trains?

❒ Yes ❒ No ❒ Never ridden bus/light rail

FUNCTIONAL ABILITIES: USING FIXED-ROUTE BUSES AND LIGHT RAIL TRAINS

What best describes <u>your</u> functional ability to use the fixed-route buses and light rail trains on <u>your</u> own? (<u>CHECK ALL THAT APPLY</u>)

- ❒ I can get to and from bus stops/stations if the distance is not too far.
- ❒ The severity of my disability or health condition can change from day to day. I can ride the fixed-route buses and light rail trains when I am feeling well, but not at other times.
- ❒ I have a disability or health condition which causes me to be unable to ride the fixed-route buses and light rail trains if the weather is extremely hot.
- ❒ I have a disability or health condition which causes me to be unable to ride the fixed-route buses and light rail trains if the weather is extremely cold.
- ❒ I am unable to travel on the fixed-route buses and light rail trains when there is rain and wind due to my disability or health condition.
- ❒ I cannot climb stairs to get on and off the fixed-route buses and light rail trains, and need the lift/ramp lowered.

- ❒ I can get to and from bus stops only if there are curb-cuts and level sidewalks.
- ❒ I have difficulty understanding or remembering all the things I would have to do to use the fixed-route buses and light rail trains.
- ❒ I can use the fixed-route buses and light rail trains if it is someplace I go all the time.
- ❒ I am unable to travel on the fixed-route buses and light rail trains during periods of darkness due to my disability or health condition.
- ❒ I use RT for some trips, but sometimes I am unable to use the bus or light rail trains due to high air pollution (smog).
- ❒ I can never use the fixed-route buses and light rail trains by myself.
- ❒ I am not really sure if I can use the fixed-route buses and light rail trains by myself.
- ❒ I am not able to use the fixed-route buses and light rail trains by myself for other reasons. Please explain:

_____

_____

_____

_____

_____

_____

_____

_____

CERTIFICATION OF APPLICANT

I understand the information I provided on this application is true and correct to the best of my knowledge. The purpose of this application is to determine if I am eligible to use Paratransit services, or if at times I can ride the RT fixed-route buses and light rail trains. I understand that falsification of information could result in a loss of Paratransit services as well as a penalty under the law.

I also understand that, at no expense to me the Regional Transit District may require that I participate in an in-person functional evaluation of my travel skills and agree to such a functional evaluation if one is necessary.

I agree to notify RT if my condition changes, if my mobility device has been replaced, if I have a new mobility device, or if I no longer need to use Paratransit service.

_____ Date_____

(Signature of Applicant or Guardian if Applicable)

Person Completing Application *If Not* the Applicant:

Printed Name_____ Relationship to Applicant_____

Signature_____ Date_____

Daytime Phone #_____ Evening Phone #_____

This concludes the applicant's portion of the application. The following page MUST be completed by a Professional.

DO NOT SEPARATE THE APPLICATION FROM THE PROFESSIONAL VERIFICATION.
BOTH SECTIONS MUST BE MAILED TOGETHER.

PROFESSIONAL VERIFICATION (REQUIRED)

To The Applicant - Please have this page completed by a professional before mailing your application to RT. Any one of the professionals listed below may sign the application. If this page is not completed and signed by one of the professionals listed below, the application will be returned to you and processing will be delayed.

↪ MUST BE COMPLETED BY A PROFESSIONAL, NOT THE APPLICANT ↩

To the Professional - Please check your professional title:

❒physician ❒physician's assistant ❒registered nurse/nurse practitioner

❒psychiatrist ❒psychologist ❒case/resource manager

❒chiropractor ❒physical therapist ❒occupational therapist

❒certified orientation & mobility specialist

The ADA regulations state that persons are eligible for paratransit service if, because of a disability or medical condition, they are physically or cognitively unable to (not discomforted by or find difficult) independently use lift-equipped public transit service. ADA paratransit eligibility is not based on the person's lack of knowledge of bus service, distance from bus service, ability to drive, language ability, or age. The information you provide will assist in determining under what circumstances this applicant may be eligible for paratransit service.

Name of Applicant: _____ DOB _____

Please describe the medical diagnosis, physical or cognitive disability which causes the applicant to be unable to independently use a lift-equipped bus or light rail train some, or all of the time. Must provide specific details or application will be returned:

_____

_____

_____

_____

_____

Is this condition temporary? ❒ No ❒ Yes; **for:** ❒4 mos ❒6 mos ❒9 mos ❒12 mos

This person ❒ is ❒ is not **able to self-supervise daily activities**

Last date of face-to-face contact with this applicant was_____/_____ /_____

I certify under penalty of perjury under the laws of the State of California that the information contained in this application is true and correct.

Signature_____ **Date** _____ /_____ /_____*

Printed Name_____ **Phone**_____

Clinic/Agency_____ **Address**_____

City _____ **State** _____ **ZIP**_____

Professional License/Registration/Certification#_____ **State**_____

******This form expires 90 days from the signature date.***

Revised August 2013

- Form does not need to be typed -

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Name of Applicant: Jane Doe **DOB** 01/02/1933

Please describe the medical diagnosis, physical or cognitive disability which causes the applicant to be unable to independently use a lift-equipped bus or light rail train some, or all of the time. Must provide specific details or application will be returned:

Patient seen by me one time on 3/31/13, 78 years old with below the knee amputation, LLE gangrene, OA spine / neuropathy / RLE Edema / Severe difficulty with ambulation

Is this condition temporary? ☑No ❒ Yes; **for:** ❒4 mos ❒6 mos ❒9 mos ❒12 mos

This person ☑is ❒ is not **able to self-supervise daily activities**

Last date of face-to-face contact with this applicant was 03 / 31 / 13

I certify under penalty of perjury under the laws of the State of California that the information contained in this application is true and correct.

Signature _____ **Date** 04 / 10 / 13 *

Printed Name Dr. William Smith **Phone** (916) 555-1234

Clinic/Agency ABC Clinic **Address** 1234 7th Avenue

City Sacramento **State** CA **ZIP** 95814

Professional License/Registration/Certification# A77777 **State** CA

**** This form expires 90 days from the signature date.***