Application for ADA Paratransit Service

IMPORTANT INFORMATION FOR APPLICANTS

This packet includes information and forms you need to apply for The County Connection LINK paratransit eligibility. As part of the requirements of the Americans with Disabilities Act (ADA), paratransit service **is provided by all public transportation systems. This special type of public transportation service** is limited to persons who are unable to independently use regular public transit, some or all of the time, due to a disability or health related condition.

In order to use ADA paratransit service, you must be certified as eligible. Eligibility is determined on a case-by-case basis. According to ADA regulations, eligibility is strictly limited to those who have specific limitations that prevent them from using accessible public transportation.

Your application may be approved for full eligibility (unconditional) or on a limited basis for some trips only (conditional eligibility). If you are found to be capable of using regular bus and rail transit for all trips, without the help of another person, you will not be eligible for paratransit.

To apply for eligibility, you must fully complete the attached application form. We will review your ability to use accessible public transportation. After studying your application, we may need more information. We may need to:

- Contact you by phone
- Schedule a personal interview or a functional evaluation.
- Consult with your doctor, health professional, or other specialist about your condition and abilities

For:

- **Braille,**
- **Large Print,**
- **Audio Tape**

Or

- **Computer Diskette/ CDR**

Call **925-680-2066 or 925-680-2067**

Your application will be processed within 21 days after it has been received.

The application must be properly completed and you must make yourself available for a second level assessment if requested. A second level assessment could include a telephone interview with you, or an in-person interview.

You will receive notice of your eligibility determination by mail. If you are certified as eligible, you will be eligible to travel on ADA paratransit throughout the nine-county Bay Area. If you do not agree with the eligibility determination, you have the right to appeal. Information on how to file an appeal will be included with your eligibility notice. If an eligibility determination takes longer than 21 days, you may be given eligibility that allows you to use the paratransit system until a final decision about your eligibility is made. This does not apply if, through inactions on your part, we are unable to complete the processing of your application.

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. **You are not required to attach additional pages or information. However, you** may want to send other documents that you think will help us understand your limitations. **All information that you supply will be kept strictly confidential.**

3. **You must provide SIGNATURES in two places to complete the application:**
   - Applicant Certification (Page 8)
   - Authorization to Release Information for an appropriate medical or rehabilitation professional (Page 9)
4. **Fax or mail the completed application to:**

ADA CERTIFICATION
County Connection
2477 Arnold Industrial Way
Concord, CA 94520
Fax: 925-852-6719

For help with the application process or to check on the status of your application call (925) 680-2066 OR (925) 680-2067

Please Print

Personal/Contact Information

Name *(first, middle, last):*

_____

Home Address: _____ Apt. #: _____

City: _____ Zip: _____

Mailing Address *(if different from home):*

_____ Apt. #: _____

City: _____ Zip: _____

Daytime Phone: (____) _____ **TDD/TTY:** (____) _____

Evening Phone: (____) _____ Cell Phone: (____) _____

Birth Date: ____/____/____ ☐ Female ☐ Male

Primary Language *(please check):* ☐ English ☐ Other *(specify)*_____

If you need any future written information provided to you in an accessible format, please check which format you prefer:

☐ Audio tape ☐ Braille ☐ Large Print ☐ Other *(specify)*
_____

In case of emergency, whom should we contact?

Name: _____

Relationship: _____

Day Phone: (____) _____ Eve. Phone: (____) _____

Tell Us About Your Disability / Health Related Condition

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

1. What is your Disability or Health Related Condition(s) that **PREVENTS** you from using regular public transit (i.e. bus, BART, streetcar) without the help of another person?

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

3. When did you first experience the conditions you described above?
   ☐ 0-1 year ago ☐ 1 – 5 years ago ☐ Longer than 5 years

4. Do the conditions you described change from day to day in a way that affects your ability to use public transit?
   ☐ Yes, good on some days, bad on others. ☐ No, doesn't change.

5. Are the conditions you described:
   ☐ Permanent ☐ Temporary
   If temporary, how long do you expect this to continue?

Tell Us About Your Capabilities and Usual Activities

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

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

The next question relates to the size & weight of your mobility device.

Please note: A wheelchair or other mobility device larger than 30" wide and 48" long when measured 2" from the floor, or weighing more than 800 lbs. when occupied, may not fit on LINK paratransit.

7. Is your mobility device bigger than the dimensions described above?
☐ Yes ☐ No

If Yes, Please provide the make and model number of device
Make: _____ Model #: _____

Does your mobility device weigh less than 800 pounds when occupied?
☐ Yes ☐ No ☐ I don't know

8. 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/someone who helps me
☐ I live independently (without the assistance of another person)

9. How many city blocks can you travel **with or without a mobility aid** and without the help of another person? _____

10. 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:_____
_____

11. 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

Tell Us About Your Travel Needs

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

☐ Buses ☐ Paratransit ☐ Drive myself ☐ BART
☐ Taxi ☐ Ferry ☐ Streetcar ☐ Someone drives me
☐ Other *(specify)* _____

13 Do you require the assistance of a Personal Care Attendant (PCA)? (A PCA is someone who **must assist** you with daily life activities: Dressing, personal hygiene, carrying packages, finding your way)

☐ Yes, I need assistance with_____
_____
_____

☐ No, I do not need assistance when I travel.

14. Would you be able to get to and from the public transit stop nearest your home?
☐ Yes ☐ No ☐ Sometimes
If no or sometimes, explain why:_____

_____

15. Would you be able to grasp handles or railings, coins or tickets/cards while boarding or exiting a transit vehicle?
☐ Yes ☐ No ☐ Sometimes ☐ Don't know, never tried it
If no or sometimes, explain why:

_____

_____

16. 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
If no or sometimes, explain why:

_____

_____

17. Would you be able to get on or off a public transit bus if it has a lift, a ramp, or a kneeler that lowers the front of the bus?
☐ Yes ☐ No ☐ Sometimes ☐ Don't know, never tried it
If no or sometimes, explain why:

_____

_____

18. The County Connection offers free travel training to anyone interested in learning how to ride the County Connection fixed-route buses. Would you be interested in having this training?
☐ Yes ☐ No

Have you answered all the questions and provided explanations where required?
INCOMPLETE APPLICATIONS WILL BE RETURNED.

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 a professional familiar with my functional abilities to use public transit must complete pages 11 thru 13 in order to assist in the determination of eligibility.

Sign here:

Applicant's signature _____

Did someone help you in filling out this form? ☐ Yes ☐ No

If yes, Name _____

Phone: (____)_____

Relationship: _____

Please Note: It is your responsibility to notify us if your disability 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.

Authorization to Release Medical Information to Verify Disability or Health Related Condition

(To be completed by applicant)

I hereby authorize the following licensed professional (doctor, therapist, social worker, etc.) who can verify my disability or health related condition, to release this information to my local public transit agency. This information will be used only to verify my eligibility for paratransit services. I understand that I have the right to receive a copy of this authorization, and that I may revoke it at any time.

Name of Professional who may release my medical information:

_____

Address:

_____

City: _____**, State:**_____**,**
Zip Code:_____

Phone #_____

Medical Record or ID #, if known:

_____

Sign here:

Applicant's signature _____

Date _____

Authorization to Disclose Application Status and Paratransit Eligibility Determination

(To be completed by applicant)

I hereby authorize County Connection LINK paratransit to disclose my paratransit application status and eligibility determination to the following individual or entity. I understand that if I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected. I understand that I have the right to receive a copy of this authorization, and that I may revoke it at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to County Connection.

Name of individual or entity who may be notified of my paratransit application status and eligibility determination:

_____

Address:

_____

City: _____, **State:** _____,

Zip Code:_____

Phone #_____

Sign here:

Applicant's signature _____

Date _____

This concludes the applicant's portion of the form.
Please have your treating physician review your application and complete pages 11 -13 before returning to the ADA Certification Department

Applicant's Name:_____
Date of Birth: _____

Licensed Medical or Mental Health Professional Verification

Please Check one:

[ ] Medical Doctor (MD) [ ] Optometrist [ ] Psychologist (Ph.D.)

[ ] Orthopedic Doctor [ ] Neurologist [ ] Psychiatrist

[ ] Ophthalmologist [ ] Spinal Specialist

[ ] Physical, or Occupational Therapist

[ ] Certified Orientation & Mobility Specialist

Instructions: This individual is applying for County Connection LINK Paratransit Services. In accordance with the Americans with Disabilities Act of 1990, as amended, paratransit service is available only for persons who, because of a disability, are **prevented** from taking the regular fixed-route bus. **All County Connection Public Transit buses are equipped with lifts for people who cannot climb stairs.** The individual could be prevented in either of the following ways: 1) is unable to independently get to and from a bus stop, on or off the bus, or successfully navigate to a destination or 2) is unable to understand how to complete a bus trip.

For the benefit of the Applicant, Please answer the following questions as fully and accurately as possible. Please be specific when answering the questions. Incomplete answers will result in the application being returned to the applicant. All healthcare information will be kept confidential. Please call (925) 676-1976 if you have any questions. Thank you for your time and cooperation

Please review the information contained on the application as provided by the Applicant or Applicant's representative.

1. **Based on your knowledge of the Applicant's condition, is the information provided on their ADA application accurate?**

   [ ] Yes [ ] No [ ] Somewhat
   If you checked "no" or "somewhat," please explain:

   _____
   _____
   _____
   _____

2. **What specific conditions contribute to the Applicant's mobility and / or cognitive limitations? Please define the degree of impairment and include visual acuity, DSM codes, GAF or IQ scores, if applicable.**

NOTE: Age or the inability to drive are not qualifying factors.

DIAGNOSIS / DISABILITY, DATE OF ONSET, DEGREE OF IMPAIRMENT

_____
_____
_____
_____
_____
_____
_____

Please explain how the Applicant's disability prevents them from using the regular bus system.

_____
_____
_____
_____
_____
_____
_____
_____

3. **The disability that prevents the Applicant from accessing the regular bus system is:**
   [ ] Permanent [ ] Temporary – Until_____

4. **Does the Applicant with his/her mobility device weigh more than 800 lbs?**

   [ ] Yes; please list applicant's present weight (with mobility device)_____ [ ] No

5. **Does the Applicant require a Personal Care Attendant (PCA) when traveling?**
   Note: A PCA is someone who is designated or employed by a person with a Disability to assist that person in meeting his or her personal needs and/or to facilitate travel for a specific trip.

   [ ] Yes [ ] No [ ] Sometimes

   If sometimes, please explain:_____
   _____
   _____
   _____
   _____

I HEREBY CERTIFY under penalty of perjury under the laws of the State of California that the information provided on the Professional Verification portion for this application is true and correct.

_____ _____ _____
Licensed Professional Signature **License number** **Date**

Printed Name: _____

Organization: _____

Address: _____

City, State, Zip: _____

Phone: _____

Thank you for your assistance in completing this form. County Connection, in accordance with the Americans with Disabilities Act of 1990, will use the information provided to determine the applicant's eligibility for Paratransit Services.