1911 Fay Street, Durham, NC 27704
(919) 560-1551
godurhamaccess.org

PARATRANSIT ELIGIBILITY APPLICATION

The paratransit systems in the region operate in accordance with the Americans with Disabilities Act (ADA) of 1990, and each program is designed to serve individuals whose disabling conditions or functional limitations prevent them from using regular, fixed-route services.

How do I apply?

If you believe you qualify, complete Part A of this application and then give both Parts A and B to a Health Care Provider who is familiar with your condition to have them complete Part B. Your signature on the application authorizes this professional to provide information to the participating paratransit system regarding your eligibility for ADA paratransit services and any needed clarification of functional limitations due to your disabling condition. The application must be properly and fully completed in order to be considered.

Return completed forms to:

GoDurham ACCESS
Attn: ADA Certification Review
1911 Fay Street
Durham, NC 27704

What happens after I turn in my application?

You will be contacted within 21 business days by a staff to schedule your functional assessment. For your assessment, you will be provided a free trip to and from a functional assessment center, to determine your eligibility based on the following factors:

a. Information you provided on your application
b. Information provided by your healthcare professional
c. A brief assessment of your actual functional abilities
d. A review of available transportation options in the area in which you desire to travel

If you have questions or have not been contacted within 21 business days of submitting your application, call the phone number(s) listed above. If, at that time, a determination of your eligibility has not been made, you will be temporarily eligible for the paratransit services until such time as your application can be reviewed.

You will receive notice of your eligibility determination by mail. 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 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 this application.

Once eligibility has been determined, your application can be transferred to other transit partners (GoTriangle, GoRaleigh, GoCary, or Chapel Hill Transit) upon request.

PART A - APPLICANT'S INFORMATION

To be completed by applicant or other authorized person, please print. Complete Part A and sign. Submit to a Health Care Provider to complete Part B.

Date of Application

Personal Information

Last Name **First Name** **MI**

Last 4 Digits of Social Security **Date of Birth** **Gender**

Male Female

Primary Language

English Spanish Other (Please specify)

Do you receive Medicaid?

Yes No

Contact Information

Home Address **Apt/Suite/etc.**

City **Zip Code**

Mailing Address (If Different from Home Address) **Apt/Suite/etc.**

City **Zip Code**

Daytime Phone Number **Cell Phone Number**

Evening Phone Number **TTYD Number (If Applicable)**

Emergency Information

Name **Relationship**

Daytime Phone Number **Evening Phone Number**

About Your Mobility

Do you use any of the following mobility aids? (Check all that apply)

- Cane
- White Cane
- Walker
- Crutches
- Prosthesis
- Other (Please Specify)
- Manual Wheelchair
- Powered Wheelchair
- Powered Scooter/Cart
- Boarding Chair
- Transfer Board
- Service Animal
- Picture Board
- Alphabet Board
- Portable Oxygen
- None of These

If you use a manual, powered wheelchair, or scooter, what year/make/model is it?

If you use a manual, powered wheelchair, or scooter, does the device (with you in it) exceed any of the following dimensions or weight?

- Width greater than 30 inches
- Length greater than 48 inches
- Combined weight (you and the device) over 600 pounds

Yes No

Is there a wheelchair ramp at your home?

Yes No

About Your Disability or Limitations

Please check all statements that describe how your disability or condition prevents you from using fixed-route bus service. Describe your specific needs in the space provided.

MOB

I have a mobility impairment which prevents me from getting to and/or getting on a fully accessible vehicle without assistance. If checked, describe the nature of this condition and any environmental obstacles (such as inclines, curbs, and distances) which affect your ability to access public transportation.

This condition is: ☐ Temporary ☐ Permanent

END

☐ I have an endurance problem which prevents me from moving the distance needed to get to the bus stop. If checked, describe the cause and nature of this condition.

This condition is: ☐ Temporary ☐ Permanent

VIS

☐ I have a visual impairment that prevents me from finding my way to and from a fixed-route bus stop without assistance. If checked, describe nature of your condition and your functional level of vision.

This condition is: ☐ Temporary ☐ Permanent

COG

☐ I have a cognitive disability which prevents me from remembering and understanding information needed to get myself safely to and from the bus stop. If checked, describe the origin and characteristics of your condition.

OTH

☐ I have a severe medical condition which limits my ability to function. If checked, describe condition and note whether your condition is temporary or permanent and if it is episodic in nature.

i.e. Do you have “good days” or times when you can access transportation and “bad days” when you cannot?

This condition is: ☐ Temporary ☐ Permanent

☐ I am declining with functional losses due to aging. I feel I am not able to access regular bus service due to the following limitations:

☐ My functional limitations do not fit into any of the above categories. I am unable to use regular bus service because:

This condition is: ☐ Temporary ☐ Permanent

Are you involved in any programs or training which will have an impact on your ability to use public transportation? If so, please describe.

Transportation Needs, Environmental or Individual Factors

Do you currently use any regular fixed-route bus services?

☐ Yes ☐ No

If yes, which routes?

What is the closest bus stop to your home?

Can you get to the bus stop by yourself?

☐ Yes ☐ No

If no, what limits you from getting there?

Please check any of the following which are applicable to your situation.

1. If I am waiting outside a bus stop, I must have:

- ☐ A bench
- ☐ A shelter
- ☐ Nothing additional

2. When crossing a street, I need:

- ☐ Curb cuts
- ☐ Accessible median
- ☐ Not more than _____ (Enter #) lanes of traffic
- ☐ Tactile curb warnings
- ☐ Audible signals
- ☐ Nothing

3. I cannot make my way across ground which is:

- ☐ Paved or sidewalk
- ☐ Grassy
- ☐ Gravel
- ☐ Hilly

4. My ability to access transportation is affected by weather which is:

- ☐ Rainy
- ☐ Icy
- ☐ Windy
- ☐ Warm (Above _____ degrees)
- ☐ Cold (Below _____ degrees)

5. My ability to access transportation is dependent on the time of day. I cannot see in:

- ☐ Full daylight
- ☐ Partial daylight
- ☐ Darkness/semi-darkness

6. My ability to access stairs is as follows. I can manage:

- ☐ Only 1 or 2 steps
- ☐ No steps
- ☐ Only with a handrail

7. The distance I can travel to and from bus stops is:

- ☐ No more than _____ feet
- ☐ At least 5 blocks

8. I can wait at a bus stop:

- ☐ No more than _____ minutes
- ☐ At least an hour

9. The bus stops which I can access:

- ☐ Must be stops for which I have received travel training
- ☐ Must be only in areas familiar to me

10. I travel

- [ ] Alone
- [ ] Only with an attendant or companion (This does not affect your eligibility)
- [ ] Both alone and with a companion

11. If you travel with someone who assists you, does this person assist you in:

- [ ] Getting to and from the bus stop
- [ ] Helping you where you are going
- [ ] Getting on or off the bus
- [ ] Other (Please describe):

12. I can cross a street with:

- [ ] 2-3 lanes
- [ ] I cannot cross
- [ ] 4-6 lanes

Please list any specific trips for which you have received travel training and the name of the Orientation and Mobility Specialist who provided the traning:

List your 5-6 frequent destinations and how you currently get there:

Destination	Frequency of travel	How you get there now

List places you would like to go but cannot currently access:

Destination	Frequency desired	Barriers to your access

Person completing form other than applicant (Please check one):

- ☐ 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.

Exceptions or additions:

Name **Daytime Phone Number**

Home Address **Apt/Suite/etc.**

City **Zip Code**

Relationship to Applicant

Signature of Preparer **Date**

Certification & Authorization for Release of Information

Please list the name of the Health Care Provider who will be verifying your application.

Name **Phone Number**

I certify that the information contained in Part A of this application is correct and I hereby authorize the above-named professional to provide verification of my condition as well as information about my condition to GoDurham ACCESS regarding my eligibility for the paratransit services.

Additionally I authorize the above-named professional to provide needed clarification of functional limitations to the Functional Assessment Organization (Durham Exchange Club Industries, Inc.)

This authorization will be valid for one year from the date signed unless otherwise noted.

Applicant's Signature **Date**

PARATRANSIT ELIGIBILITY APPLICATION CERTIFICATION OF HEALTH CARE PROVIDER

You are being asked by the applicant named in Part A of this application to provide information regarding his/her ability to use the regular fixed-route services provided by the transit systems in the region. For those persons who are not able to use the regular fixed-route services, with the accommodations provided, the transit system may allow them to use paratransit services. The information you provide will allow us to evaluate the request and determine this individual's specific needs. Thank you for your cooperation in this matter.

Please note: All regular fixed-route and connector services available within the region are currently accessible to persons with disabilities who need lift-equipped vehicles, vehicles which kneel to the curb, and/or announcement of bus stops. In order to be eligible for the paratransit services, the individual must be **unable** to access these services due to conditions which prevent them from getting to or from a fixed-route bus stop, or transferring between vehicles, and/or conditions which prevent them from being able to get on, ride, or get off a lift-equipped vehicle. Individuals for whom performing these tasks is inconvenient or uncomfortable are **not eligible** for services, and you are asked to verify this information.

It is extremely important that you provide specific information about the individual's functional limitations so that eligibility determination can be made.

Please follow these steps to verify this application:

1. Read the applicant's statements provided in Part A in its entirety
2. Fill out Part B completely using the criteria provided
3. Return completed application to applicant within 7 days of receipt (Applicant is responsible for returning application to paratransit provider)
4. Be aware that you may be contacted for further information about applicant's abilities
5. If you have questions, contact GoDurham ACCESS by calling (919) 550-1551

Applicant Name

Home Address **Apt/Suite/etc.**

City **Zip Code**

PART B - CERTIFICATION OF HEALTH CARE PROVIDER

1. I have read Part A in its entirety and I agree with the information provided.

☐ Yes ☐ No

If no, please explain:

2. Identify the condition causing this applicant's disability.

3. Specify which functional limitations are associated with this condition and be specific when asked to supply additional information.

- Mobility impairment
- Hearing impairment (Total Partial)
- Visual impairment (Total Partial)
- Compromised endurance (Muscular Respiratory)
- Other (Please specify):

What's the severity of the individual's condition?

Mild Moderate Severe Profound/chronic

***If this individual has functional limitations due to a cognitive impairment, please indicate any of the following issues that are pertinent to this individual:**

- Cannot be left alone to wait for transportation
- Displays behavior that is unsafe for self or others using public transportation
- Cannot recognize vehicles that she/he should board

What is the expected duration of this individual's condition?

- Temporary - Approximate until
- Long term - Potential for functional improvement or periods of remission
- Permanent - No expectation for functional improvement

4. For any impairment checked above, please note specific precautions that individual must follow in terms of:

Travel distanct limitations:

Limitations regarding time of day to travel:

Weather conditions:

Environmental conditions:

5. Please choose the statement below which best represents your opinion regarding this individual's use of public transportation:

- This individual should be able to access public transportation successfully.
- This individual can use public transportation under certain situations as stated above.
- This individual cannot use public transportation due to multiple functional limitations.

Signature

Print Name

Print Title

Date Signed

Business Address

Apt/Suite/etc.

City

Zip Code

Phone Number

Organization/Practice

Type of Practice

Thank you for your assistance!