## 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.

Return Completed Form to:

**Chapel Hill EZ Rider Service**
Attn: ADA Certification Review
6900 Millhouse Road
Chapel Hill, NC 27516
919-969-4900

**GoTriangle ACCESS**
Attn: ADA Certification Review
P.O. Box 13787
RTP, NC 27709
919-485-7433

**GoDurham ACCESS**
Attn: ADA Certification Review
1911 Fay Street
Durham, NC 27704
919-560-1551

### 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.

### 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.

**PARATRANSIT ELIGIBILITY APPLICATION**

**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:

Last Name: _____ First Name: _____ Middle Initial: _____

Last 4 Digits of Social Security Number: _____

Home Address: _____

City: _____ Zip: _____

Mailing Address (if different from home address): _____

City: _____ Zip: _____

Daytime Phone Number: _____ Evening Phone Number: _____

Cell Phone Number: _____ TTD Number (if applicable): _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Primary Language: ☐ English ☐ Spanish ☐ Other (please specify): _____

In case of emergency, please contact:

Name: _____ Relationship: _____

Daytime Phone: _____ Evening Phone: _____

**ABOUT YOUR MOBILITY**

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

| | | |
|---|---|---|
| ☐ Cane | ☐ Manual Wheelchair | ☐ Service Animal |
| ☐ White Cane | ☐ Powered Wheelchair | ☐ Picture Board |
| ☐ Walker | ☐ Powered scooter/cart | ☐ Alphabet Board |
| ☐ Crutches | ☐ Boarding Chair | ☐ Portable Oxygen |
| ☐ Prosthesis | ☐ Transfer Board | ☐ None of These |

☐ Other (please describe): _____

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

_____

If you use a manual, powered wheelchair, or scooter, is it more than 30 inches wide, more than 48 inches long, or does it, when in use, weigh more than 600 pounds (including person plus the mobility device)? ☐ Yes ☐ No

**ABOUT YOUR DISABILITY OR LIMITATIONS**

Please **check all that apply** of the following statements which best define the nature of your disability or limitation that prevents you from using fixed-route bus service. Describe your specific needs in the space provided.

☐ 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. (MOB)

The condition is ☐ temporary ☐ permanent

☐ 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. (END)

The condition is ☐ temporary ☐ permanent

☐ 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. (VIS)

☐ 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. (COG)

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

☐ 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?) (OTH)

_____

_____

The 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: (OTH)

_____

_____

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

_____

_____

The condition is ☐ temporary ☐ permanent

---

**TRANSPORTATIONS 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 <u>any</u> of the following which are applicable to your situation.*

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

☐ a bench ☐ a shelter ☐ nothing additional

When crossing a street, I need:

☐ curb cuts ☐ tactile curb warnings ☐ audible signals

☐ accessible median ☐ not more than____(enter #) lanes of traffic ☐ nothing

I cannot make my way across ground which is:

☐ paved or sidewalk ☐ grassy ☐ gravel ☐ hilly

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

☐ warm (above____degrees) ☐ cold (below____degrees) ☐ rainy

☐ icy ☐ windy

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

☐ full daylight ☐ partial light ☐ darkness/semi-darkness

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

☐ only one or two steps ☐ only with a handrail ☐ no steps

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

☐ no more than____feet ☐ at least five blocks

I can wait at a bus stop:

☐ no more than____minutes ☐ at least an hour

The bus stops which I can access:

☐ must be stops for which I have received formal travel training

☐ must be only in areas familiar to me

I travel: ☐ alone ☐ both alone and with a companion

☐ only with an attendant or companion (this does not affect your eligibility)

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

☐ getting to or from bus stop ☐ getting on or off the bus

☐ helping you where you are going

☐ Other (please describe): _____

_____

I can cross a street with: ☐ 2-3 lanes ☐ 4-6 lanes ☐ I cannot cross

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

_____

_____

List your 5-6 most 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 current 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 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: _____

City:_____ Zip:_____

Relationship to Applicant:_____

Signature of Preparer:_____ Date: _____

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

Name:_____

Phone Number: _____

**CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION**

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 the participating paratransit systems (specifically GoDurham ACCESS, GoTriangle ACCESS, and Chapel Hill EZ Rider Service) 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 the paratransit provider at:

| **Chapel Hill EZ Rider** | **GoTriangle ACCESS** | **GoDurham ACCESS** |
|---|---|---|
| 919-969-4900 | 919-485-7433 | 919-560-1551 |

**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 ☐ Visual Impairment ___total ___partial

☐ Hearing Impairment___total ___partial ☐ Cognitive Impairment*

☐ Compromised Endurance___muscular ___respiratory ☐ Other (please specify below)

_____

What is 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 duration until _____

☐ Long term – potential for functional improvement or periods of remission

☐ Permanent – no expectation of functional improvement

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

Travel distance 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:_____ Date Signed:_____

Print Name: _____ Print Title: _____

Business Address: _____

City:_____ Zip: _____

Phone:_____ Organization/Practice: _____

Type of Practice: _____

**THANK YOU FOR YOUR ASSISTANCE!**