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:

GoTriangle ACCESS
Attn: ADA Certification Review
P.O. Box 13787
RTP, NC 27709
919-485-7468

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 him/her 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.

PART A – APPLICANT'S INFORMATION

To be completed by applicant or other authorized person, please print. Complete all of 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 ____ White Cane ____ Manual Wheelchair ____ Powered Wheelchair ____
Service Animal ____ 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 1000 pounds (including person plus the mobility device)? Yes _____ No _____

ABOUT YOUR DISABILITY OR LIMITATIONS

Please **check all that apply** of the following statements that 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 that 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) that affect your ability to access public transportation. (MOB) _____
_____
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 that 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 that will have an impact on your ability to use public transportation? If so, please describe. _____
_____

____ I have a severe medical condition that 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) _____
_____

____ 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

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 that 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 that is:
____paved or sidewalk ____ grassy ____ gravel ____ hilly

My ability to access transportation is affected by weather that is:
____ warm (above ___ degrees) ____ cold (below ____ degrees)
____ rainy _____ icy ____ windy
My ability to access transportation depends 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 that 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 people 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 people with disabilities who need lift-equipped vehicles, vehicles that 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 that prevent them from getting to or from a fixed-route bus stop, or transferring between vehicles, and/or conditions that 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 seven (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: 919-969-4900
    - GoTriangle ACCESS: 919-485-7468
    - GoDurham ACCESS: 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 that best represents your opinion regarding this individual's use of fixed-bus route service:
____ 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!