Application for ADA Paratransit Service

IMPORTANT INFORMATION FOR APPLICANTS

This packet includes information and forms you need to apply for paratransit eligibility in the San Francisco Bay Area. 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, or
- Consult with your doctor, health professional, or other specialist about your condition and abilities

For:
Braille,
Large Print
Compact Disc/CDR

Call: (415) 351-7000

Если вы хотите иметь это заявление на русском языке, пожалуйста, позвоните по телефону (415) 351-7006

Si usted desea tener esta solicitud en español, por favor llame al (415) 351-7004

如果您想使用中文申請, 請致電 (415) 351-7005

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, medical verification, or an in-person interview. The in-person interview may include a functional test to determine your ability to take a public transit trip, such as being capable of walking to a bus stop, reading signs etc.

You will receive notice of your eligibility determination by mail. If you are certified as eligible, you will be eligible to travel 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 three places to complete the application:**

   - Applicant Certification (Page 8)
   - Authorization to Release Information for an appropriate medical or rehabilitation professional (Pages 9 and 10)

4. **Return the completed application to:**
   Mail: 68 – 12th Street, San Francisco, CA 94103
   Fax: (415) 351-3135
   Email: sfptcertification@sfparatransit.com

- For help with the application process or to check on the status of your application, please call: (415) 351-7050.

Thank you

Please Print

Personal/Contact Information

Name *(first, middle, last):*
_____ E-Mail: _____

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)* _____

Race/Ethnicity (optional): ☐ Asian and/or Pacific Islander

☐ Black and/or African American ☐ Hispanic and/or Latinx ☐ White

☐ Middle Eastern and/or North African ☐ Native American

☐ Another race or ethnicity (specify): _____ ☐ Prefer Not to State

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

☐ CD/CDR ☐ Audio tape ☐ Braille ☐ Large Print
☐ Other _____

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. Which **disability or health related conditions <u>PREVENT</u>** you from using regular public transit without the help of another person (i.e. BART, bus, streetcar)?

_____

_____

_____

_____

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.
   ☐ Don't know.

5. Are the conditions you described:
   ☐ Permanent ☐ Temporary ☐ Don't Know
   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 _____

7. 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 who help me
☐ I live independently (without the assistance of another person)

8. How many city blocks can you travel with your usual mobility aid and without the help of another person?

_____

9. 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

_____

10. 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

11. 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_____

12. Do you travel with the help of another person?
☐ Always ☐ Sometimes ☐ Never

12a. If "always" or "sometimes", what type of help do they provide?

_____

_____

13. 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:

_____

_____

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

_____

_____

15. 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:

_____

_____

16. Would you be able to get on or off a public transit bus if it has either 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:

_____

_____

17. Please add any other information that you would like us to know about your abilities.

_____

_____

_____

_____

_____

_____

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 it may be necessary to contact a professional familiar with my functional abilities to use public transit in order to assist in the determination of eligibility.

Sign here:

Applicant's signature _____ Date _____

Is there someone (e.g., relative, social worker or agency, etc.) that you would like us to notify 90 days before your eligibility expires?
☐ Yes ☐ No

If yes, Person's Name/Agency:
_____

Email address: _____ Phone: (____) _____

Relationship: _____

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 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:

_____

Medical Record or ID #, if known:

_____

Telephone _____

Fax _____

Sign here:

Applicant's signature _____ Date _____

AUTHORIZATION FOR USE OR RELEASE OF INFORMATION

(To be filled out by applicant or applicant's representative)

To: _____(Insert name of Physician or Provider)

I hereby authorize the use or disclosure of my individually identifiable health information ("Protected Health Information") as described below in this form (this "Authorization") to Veolia/SF Paratransit for purposes of determining my eligibility to receive transportation services.

Patient's Name: _____ Today's Date _____

Please send requested information to:

San Francisco Paratransit, 68 - 12th Street, San Francisco, CA 94103

Specific description of Protected Health Information to be used or disclosed:

Our applicant's, your patient's documented disability(ies) and how it(they affect his/her ability to independently use Muni or BART's otherwise accessible buses/trains.

Event after which this Authorization expires:

Professional verification of specific information being requested (see above) which allows us to make an ADA Paratransit eligibility determination.

I understand that my Protected Health Information is subject to redisclosure to the authorized recipient of the Protected Health Information pursuant to this Authorization and that the released Protected Health Information may no longer be protected by federal privacy regulations. I also understand that I may revoke this Authorization at any time by notifying you in writing, but if I do, it will not have any effect on any actions you took before you received the revocation of this Authorization.

_____ _____

Signature of individual or individual's representative Date

(Form MUST be completed before signing)

If applicable, printed name of individual's representative: _____

Relationship to the individual: _____

_____ _____

Witness Date

(This form is available in accessible formats and/or alternative languages upon request.)