ADA Paratransit Eligibility Application and Instructions

Dear Applicant,

Thank you for inquiring about applying for Cheyenne Transit’s Paratransit service. Enclosed is a copy of an application for Certification for ADA Paratransit Eligibility.

Please read the enclosed materials carefully before completing the application.

Transit Program (CTP) ADA Paratransit service at Cheyenne provides service to individuals who are unable to use the fixed-route bus service because of a disability. An inability to use fixed route service may include being unable to travel to and from bus stops, board or exit busses, or understand how to ride and use the bus system.

CTP Paratransit provides shared ride, curb-to-curb service to persons determined to be “ADA eligible” for those trips that cannot be made using the fixed route service. You may, for example, be able to use fixed-route service for some trips if stops are nearby and there are no barriers that prevent you from getting to and from the bus. At other times, you may not be able to use the bus, CTP’s Paratransit service is meant to assist you at those times.

If you need assistance completing this form or have questions, please contact our office at 307-637-6253. This letter and application are available in different formats.

After you have completed the application information, please have your licensed health care professional complete the Professional Verification section. The information you provide in this application is confidential.

PLEASE DO NOT ATTACH MEDICAL INFORMATION TO THIS APPLICATION

Revised 3-21-17
In order to be eligible to use CTP’s Paratransit service as an ADA eligible rider, your disability must prevent you from using the existing accessible fixed route bus service. In accordance with the “Americans with Disabilities Act of 1990” (ADA), there are three specific circumstances under which a person would be considered ADA eligible for Paratransit service:

1. The individual is unable, as a result of physical, visual or mental impairment, and without the assistance of another individual (other than the driver of the bus) to board, ride or disembark from any vehicle in the fixed route system, which is accessible to individuals with disabilities.

2. The individual with a disability could utilize an accessible vehicle but such a vehicle does not operate on the fixed route he/she wishes to travel.

3. The individual with a disability has a specific impairment related condition, which prevents travel to a boarding location or from a disembarking location on the fixed route system.

Disability, age and/or distance to and from a bus stop DO NOT, by themselves, qualify a person for paratransit. Inconvenience and/or decreased comfort ARE NOT a basis for qualification. The condition must PREVENT travel by fixed route bus. Please keep in mind; all fixed route buses are equipped with wheelchair lifts or ramps, along with securement devices. Whenever possible, fixed route buses are to be utilized.

The information you provide will assist us in making an appropriate determination. Our evaluation is a transportation decision, not a medical decision. All information will be kept confidential. All questions must be answered in full or the application will be considered incomplete. An incomplete application will be returned to the applicant one time. If it is submitted a second time and is still incomplete, it will be held for 60 calendar days before it is discarded. CTP may retain the services of a registered occupational therapist or a registered physical therapist if consultation about a disability is thought necessary.

Please type or print clearly.

Once the completed application and professional verification has been received, a determination of your eligibility will be made within 21 calendar days. You will be notified of your eligibility by mail. Any fees charged for the completion of certification forms are not the responsibility of the Cheyenne Transit Program. Eligibility will be valid for at least 90 calendar days (depending on eligibility criterion) and recertification is required every 3 years. If you are dissatisfied with your eligibility determination, you may appeal within sixty days of the date of the letter notifying you of your eligibility status.

In order to be eligible for this service, you must reside within 3/4 of a mile of our fixed route corridor and the time of your trip must fall within the hours of the closest CTP bus route. If you do not reside within the 3/4 radius, you must have a means of getting within our service area before transportation is provided.

This document is available in large print and Spanish upon request.
ADA Paratransit Eligibility Application

1. INFORMATION

Name ________________________________________ ☐ Female ☐ Male
            First       Middle Initial       Last
Home address: ____________________________________ Apt #: __________
City/State: ____________________________________ Zip: __________
Mailing address: ________________________________ Apt #: __________
City: ___________________________ Zip: __________
Telephone: (____) _________ Date of Birth: _____/_____/____

Please provide the name of a LOCAL friend or relative to call in the event of an emergency:

Name ________________________________________ ☐ Female ☐ Male
            First       Middle Initial       Last
Home address: ____________________________________ Apt #: __________
City/State: ____________________________________ Zip: __________
Telephone: (____) _________ Relationship:____________

Do you need information given to you in any of the following formats?
☐ Large Print    ☐ Audio Tape    ☐ Braille    ☐ Computer Disk    ☐ None

If this application is being completed by someone other than the applicant requesting certification, that person must complete the following:

Name: ________________________________________ Relationship:_____________________
Address: _______________________________________
Telephone: (Day)_________________________ (Evening)_________________________

Please check one of the items below:

☐ 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.

Signature ___________________________ Date: ___________________________
About Your Disability

Do you have a disability which prevents you from using the Cheyenne Transit Program fixed-route bus service? [ ] Yes [ ] No

If yes, please describe any and all physical, mental, visual, or functional disabilities which prevent you from using Cheyenne Transit Program fixed-route bus services.

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

1. Explain how your disability prevents you from independently using fixed-route bus service:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

2. Are the conditions you described? [ ] Permanent [ ] Temporary [ ] Vary day to day

If temporary, what is the expected duration?_____________________________

3. Do you have a medically defined cold or heat sensitivity? [ ] Yes [ ] No

Above or below what temperatures?_____________________________________

If yes, please explain:__________________________________________________

4. Do you have a visual impairment? [ ] Yes [ ] No [ ] Sometimes

If yes or sometimes, please explain:_____________________________________

5. Are you able to wait outside without assistance or support for 10 (ten) minutes?

[ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain_____________________________________

______________________________________________________________________
6. Does the extent of your disability change after medical treatment? [ ] Yes [ ] No [ ] Sometimes

If yes or sometimes, please explain: ______________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

7. Are there any other comments or additional information relating to your disability that you would like to explain? ____________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

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**Traveling To and From Bus Stops**

1. Do you currently use Public Transportation (city bus)? [ ] Yes [ ] No

2. Have you ever ridden on a Cheyenne Transit Fixed Route Bus? [ ] Yes [ ] No

If yes, when? ____________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

3. Are you able to locate fixed-route bus stops, destinations, locations, or cross streets independently? [ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain: ______________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

4. How far from your home is the nearest CTP public bus stop?
   [ ] Less than 1 block [ ] 1-2 blocks [ ] 3-4 blocks
   [ ] 5 blocks [ ] I don’t know

5. Are you able to reach and return from your neighborhood bus stop independently? [ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain: ______________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
6. Are you able to wait outside without assistance or support for ten (10) minutes?
   [ ] Yes [ ] No [ ] Sometimes
   If no or sometimes, please explain:
   ____________________________________________________
   ____________________________________________________
   ____________________________________________________

7. Are you able to travel on flat surfaces in good weather?
   [ ] Yes [ ] No [ ] Sometimes
   If no or sometimes, please explain:
   ____________________________________________________
   ____________________________________________________
   ____________________________________________________

8. Are you able to travel on slight inclines in good weather?
   [ ] Yes [ ] No [ ] Sometimes
   If no or sometimes, please explain:
   ____________________________________________________
   ____________________________________________________
   ____________________________________________________

9. Are you able to cross multi-lane streets with crosswalks?
   [ ] Yes [ ] No [ ] Sometimes
   If no or sometimes, please explain:
   ____________________________________________________
   ____________________________________________________
   ____________________________________________________

10. How do you currently travel to your most frequent destinations? (Check all that apply)
    □ Route Bus □ Paratransit □ Friend/Relative drives vehicle
    □ Walk □ School Bus □ Private Taxi, car or Van
    □ Drive myself □ Other, Please Explain: __________________________

11. Please list your three most frequent trips and how you get there now:
    A. Destination: ______________________________________________________
       Address___________________________________________________________
       How do you get there now?___________________________________________
       Times per week:______________Get there by:___________________________
B. Destination:___________________________________
Address_____________________________________________
How do you get there now?_____________________________________________
Times per week:_____________ Get there by:________________________________

C. Destination:___________________________________
Address_____________________________________________
How do you get there now?_____________________________________________
Times per week:_____________ Get there by:________________________________

12. Have you had training to learn how to travel around the community or on how to use the fixed-route buses? [ ] Yes [ ] No
   a. Would you like information about free training to use the fixed-route buses?
      [ ] Yes [ ] No

**Boarding and Alighting the Bus**

1. Can you safely and independently walk up and down three (3) 12 inch steps?
   [ ] Yes [ ] No [ ] Sometimes
   If no or sometimes, please explain:____________________________________________

2. Are you able to board a wheelchair accessible bus without assistance?
   [ ] Yes [ ] No [ ] Sometimes
   If no or sometimes, please explain:
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
Analysis of Applicants Needs

1. How far can you travel on your own or if you use a mobility aid?
   [   ] Less than 1 block   [   ] 1 block   [   ] 2 blocks
   [   ] ¼ mile (3 blocks)   [   ] ½ mile (6 blocks)   [   ] ¾ mile (9 blocks)

2. Do you use a wheelchair or scooter? [   ] Yes [   ] No
   a. How wide is it?_________________________ inches
   b. How long is it?_________________________ inches
   c. How heavy is it when occupied?_________________________ pounds

This information is not used to determine paratransit eligibility. It is the applicant’s responsibility to know the dimensions of their mobility device and the weight of it while in use.

**Please Note: In accordance with the ADA, CTP vehicles are designed to accommodate mobility devices that weigh no more than six hundred pounds when occupied. If your mobility device exceeds these specifications, please call CTP for an evaluation to determine whether we can accommodate your mobility device.

3. Do you use any of the following mobility aids or specialized equipment when traveling? Check all that apply:
   [   ] Manual Wheelchair   [   ] Long White Cane   [   ] Cane   [   ] Crutches
   [   ] Power Wheelchair   [   ] Walker   [   ] Communication Board
   [   ] **Service Animal**   [   ] Portable Oxygen Tank   [   ] Power Scooter (3 wheel)
   [   ] Crutches   [   ] Respirator   [   ] Other Aid:________________________
   [   ] Large Power Chair (exceeds ADA)

4. **What type of animal?_______________________________________
   a. What task(s) does the service animal provide?__________________________________

**Comfort/companion animals do not fall under the definition of a service animal.

If you use a wheelchair or scooter, will you use it on paratransit? [   ] Yes [   ] No [   ] Sometimes
If no or sometimes, please explain:____________________________________________________
5. Do you require an attendant (personal care, sight guide) to travel with you? An attendant may assist you with any personal or travel needs, such as crossing the street, navigating stairs, etc.

[ ] Yes  [ ] No  [ ] Sometimes

If yes or sometimes, please explain:
________________________________________________________________________
________________________________________________________________________

6. Is there anything else you want to tell us about your disability or health condition that might help us better understand your travel abilities and limitations?
________________________________________________________________________
________________________________________________________________________

Applicants Signature

I certify that the information I gave in the application is true and correct. I understand that falsification of information may result in denial of service. I understand all information will be kept confidential; only the information required to provide services I request will be disclosed to those who perform those services. The application will not be processed without application signature.

________________________________ Date:____________________________
Applicant Signature

________________________________
Applicant Name (Please Print)

If the applicant is a minor or has a legal guardian the parent or guardian must sign this application, and attest to the accuracy of the information contained herein.

________________________________ Date:____________________________
Signature of parent or legal Guardian

________________________________
Guardian Name (Please Print)
ADA PARATRANSIT ELIGIBILITY APPLICATION

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
(TO BE COMPLETED BY THE 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 the Cheyenne Transit Program eligibility certification staff or a contractor working for the agency to conduct eligibility screenings. This information will be used only to verify my eligibility for ADA paratransit services. I understand that I have the right to request and receive a copy of this authorization, and that I may revoke it at any time.

Name of Medical Professional who may release my medical information:
______________________________________________________________

Name of Medical Professional
______________________________________________________________

Address of Medical Professional
______________________________________________________________

City, State and Zip Code
______________________________________________________________

Telephone Number of Medical Professional
______________________________________________________________

Fax Number of Medical Professional
______________________________________________________________

Medical Record or Identification number, if known
______________________________________________________________

Applicant Name (Please Print) ____________________________________________

Applicant Signature:_____________________________________Date:  ______

Please return this form and the following completed form to:
Cheyenne Transit Program
322 West Lincolnway
Cheyenne, WY  82001
(307) 637-6253
Professional Verification

This part of the application form should be completed by a health care professional who is currently treating the applicant for their disability, and is authorized to provide this information to Cheyenne Transit Program.

The individual who has asked you to review and sign this application is applying to the Cheyenne Transit Program to be considered eligible for paratransit service. **ADA paratransit service is intended ONLY for those trips that the person cannot take on the regular public bus fixed route system due to his/her physical or mental disability.**

Failure to complete this form could result in denial of service for the applicant.

Applicant Name:______________________________________________________________

1. In what capacity do you know the applicant and for how long?

___________________________________________________________________________

2. Is the applicant your regular client? [ ] Yes [ ] No

3. Please indicate all the medical diagnoses of the applicant’s disability. (Please Print Clearly)

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

4. If the disability is cognitive or developmental, please supply information regarding the applicant’s functional abilities and any recent evaluations. All information will be kept confidential.

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

5. Is the condition temporary? [ ] Yes [ ] No

If yes, please specify the time from (example: 6 months) within which you anticipate the applicant to recover or next reevaluation.

___________________________________________________________________________

___________________________________________________________________________

6. How does the diagnosed disability prevent travel on ADA accessible fixed-route buses?

___________________________________________________________________________
7. Does the applicant require use of the following? (Check each, where it applies)

<table>
<thead>
<tr>
<th>Manual wheelchair</th>
<th>Yes</th>
<th>No</th>
<th>Sometimes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motorized wheelchair</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cane, Crutches, or Walker</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Animal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal care attendant</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Is the applicant able to do any of the following with the use of a mobility aid and without the assistance of another person?

<table>
<thead>
<tr>
<th>Travel ½ block?</th>
<th>Yes</th>
<th>No</th>
<th>Sometimes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Travel 1 block?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel 2 blocks?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel 4 blocks or more?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Climb three 12” steps?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. Can the applicant independently cross the street?  [ ] Yes [ ] No

10. Does weather impact the applicant’s ability to ambulate?  [ ] Yes [ ] No

   If yes, please explain and list the temperatures at which the applicant would be impacted.

   ____________________________
   ____________________________
   ____________________________

11. Please note any additional information you feel is relevant about the applicant disability and the disability preventing travel on ADA accessible fixed-route buses.

   ____________________________
   ____________________________
   ____________________________

I certify that the information contained in this application is true and correct to the best of my knowledge and ability.

Signature________________________________________Date:__________________________

Print Name__________________________________

Daytime Phone Number:_________________________Agency/Clinic:_________________

Address:____________________________________

Professional License, Registration or Certification
#:_Expires:_