

ADA Paratransit Application Instructions

Thank you for inquiring about eligibility for ADA Paratransit Service. Enclosed is a copy of our ADA Paratransit Application form. Also enclosed is a brochure that explains what ADA Paratransit Service is and who is eligible for these services. **Please read these instructions and the enclosed brochure carefully before completing the application form.**

Types of Eligibility for ADA Paratransit

If you are determined eligible for ADA Paratransit Service, you will receive one of the following types of eligibility:

Conditional Eligibility: You are able to use the fixed route buses for some of your trips and qualify for ADA Paratransit Service for other trips.

Unconditional Eligibility: Your disability or health condition **always** prevents you from using the fixed route buses and you qualify for ADA Paratransit Service for **all** of your trips.

Temporary Eligibility: You have a health condition or disability that temporarily prevents you from using the fixed route buses.

What is “ADA Paratransit Service” and Who is Eligible?

ADA Paratransit Service is a door-to-door transportation provided by the City of Huntsville to compliment the service provided by the Shuttle Bus. Service is provided for customers with disabilities who are unable, because of their disability, to use fixed route buses. Fixed route buses are the large transit buses operated on set routes by the City of Huntsville. ADA Paratransit Service is only provided in areas where fixed route buses run. If you are a person with a disability who cannot travel on the fixed route Shuttle Buses because of your disability, you may be eligible for ADA Paratransit Services.

How do I apply?

Two forms are enclosed that must be filled out completely and returned to us at the address provided below. The first form is for you or your caregiver to complete in order to provide us with the information we need to evaluate your application. The second form should be completed by your Physician or other licensed professional health care provider who is able to verify the information on your application and provide any additional information about how your disability prevents you from using fixed route transit service. Before taking the form to your Physician, you should complete and sign the Authorization to Release Medical Information at the top of that form. Once all information on both forms is completed, mail the forms to:

City of Huntsville,
Department of Parking and Public Transit
500 B Church St.
Huntsville, AL 35801

If you have questions, please call (256) 427-6811.

CITY OF HUNTSVILLE HANDI-RIDE TRANSPORTATION APPLICATION

We are requesting this information in order for Handi-Ride to serve you.
This information will not be provided to any other person or agency
except those you list on this application.

***Incomplete forms will be sent back to you.
This will slow down the certification process.***

Circle one

New Application-Or-Recertification

General Information (PLEASE PRINT OR TYPE)

Last Name: _____ First Name: _____ M/I _____

Address: _____ Apt. #: _____

City: _____ State: _____ ZIP: _____

Telephone: Home:(____) _____ Work:(____) _____ Cell:(____) _____

Date of Birth: ____/____/____ Sex: M ____ F ____

Address where Handi-Ride will pick you up, if different from above:

Emergency Contact:

Name: _____ Relationship: _____

Telephone: Home: (____) _____ Work:(____) _____ Cell:(____) _____

Did someone assist you in filling out this form? Yes: ____ No: ____

Should this person be contacted if additional information is needed? Yes: ____ No: ____

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (____) _____

Signature: _____ Date: _____

For office use only:

Date Received: ____/____/____

File#: _____ Expiration Date ____/____/____

Disability Code: _____/____

INFORMATION ABOUT YOUR FUNCTIONAL ABILITIES
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1. Please indicate the reason why you are seeking Handi-Ride eligibility:

I can use Shuttle buses to go some places, but for other places, I cannot get to or from the bus stops.

I can use Shuttle buses sometimes, but only if they are equipped with wheelchair lifts.

I can never use Shuttle buses because: Explain briefly: _____

2. Do you currently travel with a personal care attendant (Escort)?

Yes

No

3. If you travel with the assistance of an Escort, what type of assistance do they provide?

Mobility.

Medication.

Transfers.

Other: _____

4. Do you use any of the following mobility aids or specialized equipment? (Check all that apply):

I do not use any mobility aids.

Cane

White Cane

Motorized Wheelchair

Walker

Scooter

Manual Wheelchair

Leg Braces

Crutches

Respirator / Portable Oxygen Tank

Service Animal

Other _____

Please Note: A wheelchair or other mobility device must meet the definition of a "common wheelchair" as specified in the ADA regulations: i.e., not more than 30" wide and 48" long when measured 2" from the floor and must weigh less than 600lbs when occupied.

5. Using a mobility aid on your own, how far can you travel?

I cannot travel outside my house or apartment.

I can get to the curb in front of my house / apartment.

I can travel up to 200 feet.

I can travel up to ¼ mile.

I can travel up to ½ mile.

I can travel up to ¾ mile.

6. How do you currently travel? (Check all that apply).

Drive myself.

Someone else drives me.

Other: _____

Regular Bus (Shuttle).

Taxi.

7. Have you ever used the Shuttle Buses? If No skip to question # 9.

Yes

No

8. How often do you use the Shuttle Bus per month?

Less than 4 trips per month.

4 to 10 trips per month.

10 to 15 trips per month.

9. If you indicated that you do not use the Shuttle bus. Why not? (check all that apply)

The closest stop is too far from my home.

I don't know how to ride the bus.

I can't walk by myself between the bus stop and my destination.

I'm afraid to use the bus.

I don't want to use the bus.

Other (explain) _____

10. Why is it **IMPOSSIBLE** and not just difficult/inconvenient for you to now travel on a regular Shuttle bus?

11. Which of the following are you able to do? Check all that apply.

Can you:

- Ask for or follow written or oral information such as schedules.
 Calculate the correct fare.
 Put the fare in the fare box.
 Cross the street when you get off the bus.
 Follow instructions in an emergency.
 Recognize your destination while on the bus.
 Reach your destination once off the bus.

12. If you checked any of the above, how does your disability make it impossible for you to travel on the regular Shuttle bus? Please explain in detail:

13. Can you independently get on and off a lift-equipped bus?

- Yes
 No

14. Can you maintain balance while seated on a moving vehicle?

- Yes
 No

15. Can you climb three (3) 10" steps?

- Yes
 No

16. Can you find a seat by yourself without assistance of another person?

- Yes
 No

17. List your 3-4 most frequent destinations and how you currently get there.

Destination Address	Frequency of Travel	How do you currently get there?

For Applicants with Vision Disabilities
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1. Cause of vision loss/diagnosis _____
2. Are you totally blind? Yes ___ No ___
3. My vision is worse during these conditions:

___ Bright Sunlight	___ Dimly lit or shaded places
___ Nighttime	___ About the same in all lighting
4. My eye condition is considered to be:

___ Stable
___ Degenerative
___ Other (please explain) _____
5. I am able to use my vision consistently to identify the following signs and environmental features, as they relate to traveling to the transit stop and using fixed route service. Please check all that apply:

___ The color of traffic lights
___ Level changes along the walking path
___ Pedestrian Walk/Don't Walk signals
___ Crosswalk markings
___ Curbs or curb ramps
___ Bus / Transit stop signs
6. Most often, I use the following mobility aids when I walk outdoors:

___ Sighted (person) guide
___ Dog guide
___ Long white cane
___ Optical devices (telescope, light, special glasses, etc.)
___ None of the above
___ Other (Please List) _____

CERTIFICATION OF APPLICATION

I hereby certify that, to the best of my knowledge, information given in this application is correct. I understand that the application will be returned if it is not completed. I further understand that the results of this review will be based on my ability to use the regular bus (Shuttle) transportation and may require additional information from me, such as additional consultation from my physician or other professional. I understand that failure to adhere to the policies and procedures for using Handi-Ride may be grounds for suspension or revoking my eligibility to participate in this program.

Applicant's Signature: _____ Date: ___/___/___

Please review each of your answers to make sure that you have completed all of the questions to the best of your ability.

***** Thank You *****

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(TO BE COMPLETED BY APPLICANT)

I hereby authorize the following licensed professional who can verify my disability or health related condition to release information to The City of Huntsville Public Transit Division. This information will be used only to verify my eligibility for paratransit services. I understand that I have a 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: _____

City: _____ State: _____

Zip Code: _____ Phone: _____

Applicants Signature: _____ Date: _____

Instructions for Medical Verification Form

To be completed by Doctor/Health Care Professional

It is important to determine if the above applicant is applying because using ADA Paratransit is seen as a more convenient option, or if their disability/health conditions "prevent" fixed route travel some or all of the time.

The above named applicant has indicated that you can provide information regarding his/her disability and its impact upon his/her ability to utilize our transit services. The City of Huntsville Department of Public Transportation will provide Paratransit services to eligible persons whose disability prevents them from utilizing available fixed route services. The information you provide will allow us to make an appropriate evaluation of this request and its application to specific trip requests. Thank you for your cooperation in this matter.

Disabled for our purposes is defined as: Any person who by reason of illness, injury, congenital malfunction, other permanent or temporary incapacity or disability is unable, without special facilities, to use local transit Shuttle Buses as effectively as persons who are not so affected.

Capacity in which you know the applicant: _____

Medical diagnosis of condition causing disability (layman terms please): _____

If diagnosis is a seizure disorder or psychiatric disability, is condition currently controlled by medication? _____

Date of onset: ____/____/____

How long have you known or worked with the applicant? _____

When did you last see the applicant? _____

Is the condition temporary? Yes ___ No ___ expected duration? _____

Expected duration: ____/____/____

IF THE PERSON HAS A DISABILITY AFFECTING MOBILITY: IS THE PERSON....

Able to walk 200 feet without assistance? Yes___ No___

How many city blocks can they walk? 0 -1 -2 -3 -4 -5 -6 -7 -8 -9. PLEASE CIRCLE ONE.

Able to climb three 10-inch steps without assistance? Yes___ No___

If sometimes, explain: _____

Able to wait outside without support for 10 minutes? Yes___ No___

If sometimes, explain: _____

Does this individual require an escort for transportation? Yes ___ No ___

If sometimes, explain: _____

Does this person use any mobility aids? If so what? _____

IF THE PERSON HAS A VISUAL IMPAIRMENT:

Visual Acuity with best correction:

RIGHT EYE _____ LEFT EYE _____ BOTH EYES _____

Visual Fields:

RIGHT EYE _____ LEFT EYE _____ BOTH EYES _____

IF THE PERSON HAS A COGNITIVE DISABILITY: IS THE PERSON ABLE TO?

Give address and telephone numbers upon request? Yes ___ No ___

Recognize a destination or landmark? Yes ___ No ___

Deal with unexpected situations or unexpected changes in routine? Yes ___ No ___

Ask for, understand and follow directions? Yes___ No ___

Safely and effectively travel through crowded and/or complex facilities? Yes ___ No ___

Are there any other effects of the applicant's disability which the City of Huntsville's Department of Transportation should be aware? Please Describe. _____

Your name and title: _____

Office Address: _____

Office Phone Number: (____) _____

The information on this application is true and correct to the best of my knowledge.

Signature: _____ Date: _____