Tri Delta Transit
ADA Paratransit Application Packet.

This packet contains the following:

1) Information/instructions for completing your application
   (pages 2-3)

2) ADA Paratransit Application (pages 3 – 12)

3) Medical Verification Form to be completed by your medical
   professional (pages 13 – 15)
ADA Paratransit Transportation Eligibility

Eligibility is determined on a case-by-case basis in accordance with the Americans with Disabilities Act (ADA). Disabled status is strictly limited to those who have limitations that prevent them from using accessible fixed route transportation. If you are found to be capable of using fixed route bus service, you will not be eligible for ADA Paratransit transportation.

To apply for eligibility, you must fully complete and return the attached application and Medical Verification Form. We will review your ability to use accessible fixed route transportation. After reviewing your application and the information provided by your health care professional, we may need to contact you by phone or schedule a personal interview or a functional evaluation. The functional evaluation will help us determine your ability to take a public transit trip.

Once your fully completed application and medical verification form is received your application will be processed within 21 days. You will receive notice of your eligibility determination by mail.

If you are certified as ADA eligible, you can travel on Tri Delta Transit’s ADA Paratransit transportation system as well as on paratransit systems throughout the nine-county Bay Area. If you are found to be ineligible and 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 determination letter if your ADA status is denied.
Instructions to Apply for ADA Paratransit Transportation

1. Complete the entire application: Please PRINT OR TYPE full responses to all questions on the application form. If any questions are not answered, your application will be considered incomplete. Incomplete applications will be returned.

2. Sign the following two pages:
   1) PAGE 10: Applicant Certification
   2) PAGE 12: Medical Release Form

3. Have your physician or medical professional complete the Medical Verification form, pages 13 - 15

4. If you require a personal care attendant, complete and sign the form entitled Certification for Personal Care Attendant (page 9).

5. Fax or mail your completed application and medical verification form in the enclosed addressed envelope.

   Tri Delta Transit Paratransit
   801 Wilbur Ave
   Antioch, CA 94509
   Fax: 925-757-2530

- For help with the application process call (925) 754-6622
- All information that you supply on your application will be kept strictly confidential.
ADA Paratransit Application
(Please Print or Type)

Name (first, middle, last):
_____________________________________________________________

Home Address: ____________________________________________ Apt. #: _________
City: _______________________________________________________ Zip: ______

Mailing Address (if different from home):
______________________________________________ Apt. #: _________
City: ___________________________________________ Zip: __________

Cell Phone: (____) _____________ TDD/TTY: (____) _____________

Home Phone: (____) _____________

Birth Date: ____/____/____  □ Female    □ Male

Primary Language (please check): □ English    □ Other (specify) _______

If you need any future written information provided to you in an accessible format, please check which format you prefer:
□ Diskette/CDR    □ Audio tape    □ Braille    □ Large Print    □ Other

In case of emergency, whom should we contact?
Name: _________________________________ Relationship: _________________

Cell Phone: (____) _______________ Home Phone: (____) _______________

If there is a medical emergency, where do you want to be transported?
Hospital: _________________________________ City: ___________________
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. What is your Disability or Health Related Condition(s) that **PREVENT** you from using regular public transit without the help of another person (i.e. bus, BART, 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.

5. Are the conditions you described:
   - ☐ Permanent  ☐ Temporary

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

8. 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)

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  
   *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 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.
Certification for Personal Care Attendant (Optional)

A personal care attendant is someone whose help you need for daily life activities (eating, dressing, personal hygiene, carrying packages, finding your way, etc.). An attendant does not always have to be the same person.

Tri Delta Transit paratransit drivers are not personal care attendants, nor does the Americans with Disabilities Act require Tri Delta Transit to provide you with an attendant. Tri Delta Transit reserves the right to contact your healthcare professional to verify your need for an attendant.

Verification

I, ___________________________ certifY that due to my disability or health related condition, I require the services of a personal care attendant to assist me and to travel with me when I use Tri Delta Transit paratransit transportation.

I understand that fraudulently claiming to travel with an attendant to avoid paying a fare for a companion may result in suspension of service.

____________________________________________________
Signature

____________________________________________________
Date
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 a professional familiar with my functional abilities to use public transit must complete pages 12 thru 14 in order to assist in the determination of eligibility.

**Sign here:**

Applicant’s signature ________________________________

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.
Paratransit Rider Responsibility

Tri Delta Transit is committed to providing safe, secure, and reliable service to our customers. To ensure this level of service, the cooperation and support of our customers is critical. It is for this reason that the following rules have been adopted.

I, ________________________________ understand that it is my sole responsibility, or that of my Power of Attorney or Conservator to contact Tri Delta Transit with any of the following changes during the course of my registration with Tri Delta Transit’s paratransit service:

• My name, address and/or telephone number
• Emergency contact’s name and/or phone number
• Type of mobility device
• Change(s) to physical or mental condition
• Need for a personal care attendant

_____________________________________________________
Signature

_____________________________________________________
Date

Please note: All 14 pages of this application must remain attached. If the application is received without all 14 pages, it will be considered incomplete.
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:
_________________________________________________________

City: ________________________, State: _________, Zip Code: ________

Phone #______________________________

Medical Record or ID #, if known:
__________________________________________________________

Sign here:

Applicant’s signature _______________________________________

Date _______________________________________________________

STOP

This concludes the applicant’s portion of the form. Please have your treating physician review your application and complete pages 13 – 15 before submitting to Tri Delta Transit.
Medical Verification Form

*(To be completed by a licensed medical or mental health professional)*

Applicants Name: ________________________________________________

Date of Birth: ________________________________________________

Licensed Medical or Mental Health Professional Verification

Please Check one:

- [ ] Medical Doctor (MD)
- [ ] Optometrist
- [ ] Psychologist (Ph.D)
- [ ] Orthopedic Doctor
- [ ] Neurologist
- [ ] Psychiatrist
- [ ] Nurse Practitioner
- [ ] Spinal Specialist
- [ ] LCSW
- [ ] Physical, or Occupational Therapist
- [ ] Ophthalmologist
- [ ] Certified Orientation & Mobility Specialist

**Instructions:** This individual is applying for Tri Delta Transit Paratransit Services. In accordance with the American’s with Disabilities Act of 1990, paratransit service is available only for persons who because of a disability, are prevented from taking the regular fixed-route bus. All Tri Delta Transit public transit buses are equipped with ramps/lifts for people who cannot climb stairs. The individual could be prevented in either of the following ways: 1) is unable to independently get to and from a bus stop, on or off the bus, or successfully navigate to a destination or 2) is unable to understand how to complete a bus trip.

For the benefit of the Applicant, please answer the following questions as fully and accurately as possible. Please be specific when answering the questions. Incomplete answers will result in the application being returned to the applicant. All healthcare information will be kept confidential. Please call (925) 754-6622 if you have any questions. Thank you for your time and cooperation.

Please review the information contained on the application as provided by the Applicant or Applicant’s representative.
1. Based on your knowledge of the Applicant’s condition, is the information provided on their ADA application accurate?

[ ] Yes               [ ] No               [ ] Somewhat

If you checked “no” or “somewhat” please explain:
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

2. What specific conditions contribute to the Applicant’s mobility and / or cognitive limitations? Please define the degree of impairment and include visual acuity, DSM codes, GAF or IQ scores, if applicable.

NOTE: Age or the inabilities to drive are not qualifying factors.

**DIAGNOSIS / DISABILITY / DATE OF ONSET / DEGREE OF IMPAIRMENT**

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

Please explain how the Applicant’s disability prevents them from using the regular bus system.
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

3. The disability that prevents the Applicant from accessing the regular bus system is:
[ ] Permanent    [ ] Temporary – Until ________________

4. Does the Applicant with his/her mobility device weigh more than 600 lbs?
   [ ] Yes; please list applicants present weight ____________    [ ] No
5. Does the Applicant require a Personal Care Attendant (PCA) when traveling?
Note: A PCA is someone who is designated or employed by a person with a Disability to assist that person in meeting his or her personal needs and/or to facilitate travel for a specific trip.  [ ] Yes    [ ] No    [ ] Sometimes

If sometimes, please explain:

________________________________________________________________
________________________________________________________________
________________________________________________________________

I HEREBY CERTIFY under penalty of perjury under the laws of the State of California that the information provided on the Professional Verification portion for this application is true and correct.

Licensed Professional Signature  License number  Date

Printed Name: ____________________________________________

Organization: _____________________________________________

Address: _________________________________________________

City: ________________________________ State: ________ Zip: _________

Phone: _______________________________

Thank you for your assistance in completing this form. Tri Delta Transit, in accordance with the American’s with Disabilities Act of 1990, will use the information provided to determine the applicant’s eligibility for Paratransit Services.