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 specialists about your condition and abilities

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 or medical verification.

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.

APPLICATION FOR ADA PARATRANSIT

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:
SamTrans Accessible Transit Services
Paratransit Eligibility
501 Pico Blvd
San Carlos, CA 94070

Fax: (877) 318-1431
Email: ParatransitApps@samtrans.com

Thank You

To check on the status of your application, please call: 650-366-4856.

APPLICANT PERSONAL CONTACT INFORMATION (PLEASE PRINT)

New Applicant □ **Re-certification Applicant □**

If re-certifying, please list Redi-Wheels/ Redi Coast Number: _____

Last Name: _____ **First Name:** _____ MI: _____

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Date of birth: _____

Subdivision/Apartment Complex Name/Gate Code: _____

Nearest major intersecting street: _____

Mailing Address (If different from home address)

Street Address: _____

City: _____ State: _____ Zip: _____

Gender: □ Male □ Female

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

In case of emergency, whom should we contact?

Name: _____

Relationship: _____

Home Phone: **(_____)** _____ Cell Phone: **(_____) _____**

Tell us about your disability or 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 PREVENT you from using regular SamTrans buses (regular public transit) without the help of another person?

_____
_____
_____
_____

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. Is this condition temporary? ☐ Yes ☐ No ☐ 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 _____ Portable oxygen

_____ Walker _____ Manual Wheelchair

_____ White cane _____ Motorized Wheelchair

_____ Leg Braces _____ Scooter

_____ Crutches _____ Other (Please specify: _____)

7. Do you use a service animal? ☐ Yes ☐ No ☐ Sometimes

If yes, what type of animal and for what purpose was the animal trained?

_____

8. Do you require someone to travel with you to provide personal transportation assistance?

☐ Yes ☐ No ☐ Sometimes

What type of help do they provide? _____

9. 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)

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

11. 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 _____

12. 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

13. How do you currently travel to your frequent destinations? (Check all that apply):

☐ Buses ☐ Paratransit ☐ Drive me ☐ BART
☐ Taxi ☐ Uber / Lyft ☐ Someone drives me
☐ Other _____

14. Would you be able to get to and from the public transit stop nearest your home?

☐ Yes ☐ No ☐ Sometimes ☐ Don't know, never tried it

If no or sometimes, explain why: _____

15. 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: _____

16. 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: _____

17. 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: _____

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

_____

_____

19. Have you received travel training to teach you how to use SamTrans bus service?

☐ Yes ☐ No

If yes, where? _____

20. Are you interested in learning to ride regular SamTrans buses?

☐ Yes ☐ No

Please remember to complete and sign the last three pages.

Applicant Certification

I certify that the information in this application is true and correct. I understand that knowingly falsifying the information will result in a 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 to assist in the determination of eligibility.

Sign here:

Applicant's signature _____ Date _____

Did someone help you in filling out this form? ☐ Yes ☐ No

Name_____ **Relationship**_____

Address_____

Home Phone: (_____) _____ Cell Phone: (_____) _____

I certify, to the best of my knowledge, that the information provided in this application is complete and correct based upon the information given me by the applicant or my own knowledge of the applicant's health condition or disability.

Signature _____ Date _____

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 reapply.

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: _____

Applicant's Name

_____

(Please print)

Sign here:

Applicant's signature _____ Date _____

Authorization for use or release of information

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 (the "authorization") to Medical Transportation Management, Inc., and San Mateo County Transit District for purposes of determining my eligibility to receive transportation services.

Patient name: _____ Today's date _____

Please send requested information to:

SamTrans Accessible Transit Services - Paratransit Eligibility
501 Pico Blvd., San Carlos, CA 94070

A specific description of protected health information to be used or disclosed:
Our applicant's, your patient's documented disability (or disabilities) and how they affect his/her ability to independently use San Mateo County's otherwise accessible buses.

Even after this authorization expires:
Personal 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 re-disclosure 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: _____