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 <u>need</u> information given to you in any of the following formats?

☐ Large Print ☐ Verbal ☐ Braille ☐ Flash drive ☐ 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: _____

Created 11-29-2021

About Your Disability

Do you have a disability which prevents you from using the Casper Area Transit Program fixed-route bus service (LINK)? ☐ Yes ☐ No

If yes, please describe any and all physical, mental, visual, or functional disabilities which prevent you from using Casper Area 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?
   _____
   _____
   _____
   _____

Traveling To and From Bus Stops

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

2. Have you ever ridden on a Casper Area 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 Casper Area Transit 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, Casper Area Transit 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 Casper Area Tranit 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 Casper AreaTransit 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:
Casper Area Transit Program
1715 East 4th Street
Casper WY 82601
(307) 235-8273

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 Casper Area Transit Program.

The individual who has asked you to review and sign this application is applying to the Casper Area 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)

	Yes	No	Sometimes
Manual wheelchair	____	____	
Motorized wheelchair	____	____	
Cane, Crutches, or Walker	____	____	____
Service Animal		____	____
Personal care attendant			____

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?

	Yes	No	Sometimes
Travel ½ block?			
Travel 1 block?			
Travel 2 blocks?	____	____	____
Travel 4 blocks or more?	____	____	____
Climb three 12" steps?	____	____	____

a. If "no" or "sometimes," describe in detail any factors which would have an adverse impact on the applicants abilities to travel._____
_____
_____

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:_____