Transit Management of Beaumont

Application for Certification of ADA Paratransit Eligibility

The Americans with Disabilities Act of 1990 (ADA) is federal legislation prohibiting discrimination against people with disabilities. One of the overriding principles of the ADA is to ensure that all people have equal access to public transportation. To ensure this access, public transit vehicles and facilities are required to be fully accessible and usable by persons with disabilities. For people who are unable, due to a physical or mental disability (including mobility or cognitive impairments) to independently use the public fixed-route transportation regular bus, paratransit services must be made available.

If you believe that you have a disability (including mobility or cognitive impairments), which prevents you from independently using public fixed-route transportation facilities and/or vehicles, please complete this application form and return it to the ***BEAUMONT ZIP*** office located at 550 Milam St. Beaumont, Texas 77701. The questions on this application are designed to aid in determining your functional abilities.

Your completed application will be reviewed and a decision regarding your eligibility for paratransit services made within twenty-one (21) days. You may be found eligible for paratransit services for all your travel needs, eligible (based on your abilities) for some requests but not for others, or you may be found capable of using the fixed-route facilities and vehicles. If you disagree with the decision made regarding your eligibility status, you may appeal the decision. It is possible that upon review of your application, you may be asked to provide additional information. This may include contacting a licensed professional familiar with your functional abilities, a phone or personal interview, or a physical or cognitive functional evaluation.

All information requested throughout the certification process will be kept confidential.

It is important to complete all parts of this form -- type or print, please. Applications that are not complete or clearly written will be returned, which will delay the eligibility determination process.

PART 1. *General Information*

First Name ____ Middle Initial__________

Last Name ____ Sex: M_____ F ______

Street Home Address: _____________________________________ Apt.#: _________________

City: _____________________________State: _____________ ZIP: _____________________

Mailing Address (if different from Home): ________________________ Apt.#: ______________

Cell Phone: (____) ________________TDD/TTY: (____) ___________________________

Home Phone: (____) ___________________ Birth Date: ____/____/____

If assistance was provided in filling out this form, please indicate by whom:

Name: ___________________________ Phone: (______) __________________

Relationship: ______________________________

Please indicate if this person should be contacted directly if additional information is requested.

❑ Yes No

Please give us the name and phone number of a friend or relative we can call in case we are unable to reach you at your regular number:

Name: _______________________________ Relationship: __________________________

Daytime Phone: (______) _________________ Evening Phone: (______) _________________

PART 2. ***Please answer the following questions in detail -- your specific answers to the questions will help us in determining your eligibility.***

1.

a. What is your disability or health related condition that prevents you from using public transit?

____

b. Explain HOW your disability or health related condition prevents you from independently using the public transit services (BMT ZIP buses).

____

____

c. Are the conditions you described permanent ______or temporary _____? (Please check one.) If temporary, how long do you expect this to continue? ____________________________________

2. How do you currently travel to your most frequent destinations? Check all that apply:

_____ Public Buses
_____ Someone drives me
_____ Drive myself
_____ Paratransit
_____ Taxi
_____ Other: _________________________

3. Does your health condition or transportation disability change from day to day in a way that affects your ability to use public buses?

❑ Yes, good on some days, bad on others. ❑ No, does not change. ❑ Don't know. If yes or do not know is selected, explain why:

____

____

For questions 4 through 12, please indicate whether you are independently able to perform the following functions. ALL no or sometimes answers must be accompanied by an explanation, or the application will be considered incomplete.

4. Are you able to understand directions needed to complete a trip? (This does not refer to being unaccustomed to the English language.) ❑ Yes No Sometimes (If no or sometimes is selected, explain why):

____

____

5. Are you able to identify the correct public transit stop? ❑ Yes ❑ No Sometimes If no or sometimes is selected, explain why:

____

____

6. Are you able to identify the correct public transit vehicle? ❑ Yes ❑ No Sometimes If no or sometimes is selected, explain why:

____

____

7. Are you able to get to and from the nearest public transit stop? ❑ Yes ❑ No Sometimes If no or sometimes is selected, explain why:

____

____

Note how many city blocks you can independently travel: ______________________

8 Are you able to wait at least 15 minutes at a public transit stop? ❑ Yes ❑ No Sometimes If no or sometimes is selected, explain why:

____

____

Could you wait longer than 15 minutes?

❑ Yes ❑ No Sometimes

If so, how long? ________________(Minutes)
Could you wait if there were a seat or bus shelter? ❑ Yes ❑ No Sometimes

9. Are you able to get on and off the public transit vehicle without assistance?

If no or sometimes is selected, explain why:

____

____

10. Are you able to get on or off a public transit bus if it has a lift or if the front of the bus is lowered?
❑ Yes
❑ No

❑ Sometimes
❑ Do not know, never tried it.
If no or sometimes is selected, explain why:

____

____

11. Are you able to grasp handles or railings, coins or tickets while boarding or exiting the transit vehicle?
❑ Yes
❑ No
❑ Sometimes
If no or sometimes is selected, explain why:

____

____

12. Are you able to maintain balance and tolerate public transit vehicle movement when seated?
❑ Yes
❑ No
❑ Sometimes
If no or sometimes is selected, explain why:

____

____

13. Have you ever had any training or instruction to learn how to use the public transit bus?
❑ Yes
❑ No
If yes is selected, where and when did you receive this training.

____

____

14. Is the public transit you need accessible?
❑ Yes
❑ No
❑ Sometimes
❑ Do not know, never tried it. If no or sometimes is selected, explain in what way is it not accessible?

____

____

____

15. Do you use any of the following mobility aids or specialized equipment? Check all that apply.

[____] Manual Wheelchair*
[____] Electric Chair*
[____] Powered Scooter*
[____] Communication Board
[____] Breathing Apparatus (Portable O_2)
[____] Guide Dog / Service Animal
[____] Walker
[____] Cue Cards
[____] Other ____________________________________
[____] Cane
[____] White Cane
[____] Prosthesis
[____] Leg Braces
[____] Crutches
[____] Personal ID

16. Does a Personal Care Attendant (PCA) and or service animal accompany you when you travel outside your home? Note: A PCA 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. A service animal is trained to aid and is not a pet.

❑ Yes
❑ No
❑ Sometimes

If Yes or Sometimes, please provide the name of the PCA and/or the type of service animal:

____

17. Do you currently use paratransit service? (Please check one):

❑ Yes
❑ No
❑ Sometimes

If yes or sometimes is selected, when do you use paratransit service? ________________________

Please give paratransit provider's name: ____

PART 3. ***Signature: Please Complete Box A <u>Unless</u> you are a Minor or Have a Legal Guardian, in Which Case Your Parent or Legal Guardian Should Complete Box B.***

A. I certify that the information in this application is true and correct. I understand that falsification of the information may 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 it may be necessary to contact a professional familiar with my functional abilities to use public transit to assist in the determination of eligibility.

Applicant's signature ___________________________________ Date ________________

B. I understand that the purpose of this application is to determine if the Applicant is eligible to use ADA Paratransit Services. I certify that the information provided in this application is true and correct. I understand that falsification of information could result in a loss of ADA Paratransit Services as well as a penalty under the law. I agree to notify the TRANSIT MANAGEMENT OF BEAUMONT if the Applicant no longer needs to use ADA Paratransit Services.

I consent to the Applicant's interview and the functional assessment of his/her travel abilities and limitations to determine ADA Paratransit eligibility. I acknowledge that I may be present during the interview and any functional assessment, and state that:

(Check one of the following) ____

I will be present.

_____ I designate _______________________________________to be present on my behalf, or

_____ I waive my right to be present and do not designate another person to be present on my behalf.

____ Date ____________________ (Signature of Parent or Legal Guardian)

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

(Must be completed by Applicant)

Disability verification by a qualified license physician does not guarantee eligibility for paratransit services transportation, but it can play a major role in the eligibility determination process. It is important that any professional that verifies an individual's disability be familiar not only with that person's particular disability, but also his/her ability or inability to travel on Beaumont Zip's regular bus system.

Statement of Release

I, the undersigned, understand that the medical information requested is confidential and will not be shared with any other person or agency. I hereby authorize the release of all medical records and/or information by the professionals listed below to the Transit Management of Beaumont for the express purpose of determining my eligibility for paratransit services.

Qualified Professionals

Note: Only a Licensed Physician is authorized to verify your disability.:

Name of License Physician ____

Address ____

City ___________________________________State _____________Zip Code _____________

Office Telephone Number ____

Applicant Name (please print) ____

Applicant Signature (required)______________________________________Date_____________

PART 4: DISABILITY VERIFICATION FOR DEMAND RESPONSE TRANSPORTATION

This Section to be Filled out by a LICENSE PHYSICIAN. Please Print.

Dear Physician:

The person submitting this booklet to you has indicated that you can provide information regarding his/her disability and its impact upon his/her ability to utilize public transit services.
The Americans with Disabilities Act of 1990 requires the TRANSIT MANAGEMENT OF BEAUMONT to provide demand response transportation to persons who, due to their disability, cannot utilize the regular bus system. Three categories established by the Disability Act are as follows:

1. Persons who, because of their disability, cannot independently board, ride, and/or disembark from an accessible vehicle.
2. Persons who, because of their disability, cannot use vehicles without lifts or other accommodations.
3. Persons who, because of their disability, cannot get to or from a boarding or disembarking location.

The information you provide, as authorized on page 8 of this booklet, will allow us to make an appropriate evaluation of this request and its application to specific trip requests.

Disability verification is mandatory for all applicants for demand response transportation service. While verification by a physician is not required, any professional that verifies an individual's disability must have a detailed, first-hand knowledge of that person's disability, as well as the training and credentials necessary for such an evaluation.

Please describe your professional status (Licensed Physician) *and* your methods of evaluating the applicant's disability.

____

____

Please describe the applicant's current disabling condition.

____

____

Is the condition or disability temporary?

____Yes ____ No If yes, expected recovery ____/____/_____ (______ months)

Physical Disabilities

Using a mobility aid, or on his /her own, how far is the applicant able to travel without the assistance of another person?

❑ Less than 200 ft. ❑ Less than 200 ft. ❑ Two Blocks
❑ ¼ Mile (3 blocks ❑ ½ Mile (6 blocks) ❑ ¾ Mile (9 blocks)
❑ More than ¾ Mile ❑ Other

Can the applicant climb three 12-inch steps using handrails without the assistance of another person?

❑ Yes ❑ No Sometimes

Can the applicant wait outside without support or supervision for ten (10) minutes?

❑ Yes ❑ No Sometimes

Does the applicant require special assistance and/or the use of any mobility aids? Please describe.

____

Please provide the approximate weight of the patient.

____

What is the Model and Serial number of the mobility aid?

____

Does the applicant with his/her mobility unit weigh more than 600 lbs.?
❑ Yes ❑ No Weight____________

If the applicant falls, can he/she get up independently?

___Yes _____ No _____ Sometimes

Can the applicant negotiate traffic safely and independently?

❑ Yes ❑ No Sometimes

Visual Disabilities

If the applicant has a visual impairment, please provide his/her acuity with best correction:

Right Eye_____ Left Eye _____ Both Eyes _____

Visual Fields: Right Eye_____ Left Eye _____ Both Eyes _____

Cognitive Disabilities

Is the applicant able to consistently state his/her name, home address, and home or emergency telephone numbers upon request?
❑ Yes ❑ No

If no, please explain____

Is the applicant able to recognize a destination or landmark?
❑ Yes ❑ No

If no, please explain____

Is the applicant able to manage unexpected situations or an unexpected change in routine?
❑ Yes ❑ No

If no, please explain____

Is the applicant able to ask for, understand, and follow directions?
❑ Yes ❑ No

If no, please explain ____

Is the applicant able to safely and effectively travel through crowded and/or complex facilities?
❑ Yes ❑ No

If no, please explain ____

Can the applicant negotiate roadway crossing safely and independently?
Yes ❑ No If no, please explain ____

____

Other Factors

(This information is required for all applicants)

Please describe any other functional limitation(s) with respect to bus travel. Please be specific.

____

____

Can the applicant read and/or understand information signs?

❑ Yes ❑ No

If no, please explain____

Does the applicant require a Personal Care Attendant (PCA) when traveling?

It is important to consider that Operators are NOT TRAINED to provide medical assistance, nor can they monitor medical conditions while operating / driving the Bus / Vans. Riders must be able to remain in their seat / mobility device without assistance. The safety of our passengers is our primary concern thus we ask for thorough consideration when selecting whether the rider should have a PCA when utilizing public transportation services (Zip Paratransit).

Note: A PCA 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. A service animal is trained to aid and is <u>not</u> a pet.

Does the patient require an individual with medical knowledge to perform a safety sensitive task that could result in immediate death or life threatening to their health.

❑ Yes ❑ No ❑ Sometimes

If sometimes, please explain:

____

____

Please identify any special requirement of the applicant, particularly the need to travel with a respirator or portable oxygen supply.

____

____

Please describe if any other aspects of the applicant's disability that might affect travel.

____

The information obtained in this Americans with Disabilities (ADA) certification process will only be used by the TRANSIT MANAGEMNT OF BEAUMONT to determine the applicant's eligibility for Paratransit demand response transportation services and will only be shared with other transit providers or transportation programs to facilitate travel and/or coordinate services. This information will be kept confidential and will not be used for any other purpose, unless authorized in writing by the applicant.

I understand that Disability Verification by a qualified professional does not guarantee eligibility, but it can play a major role in the eligibility determination process. Therefore, I hereby certify that I am familiar with the applicant's particular disability and with the applicant's ability or inability to travel on the Zip's regular bus system.

BMT Zip staff is hereby authorized to contact me or staff members in my office, if necessary, to complete the eligibility determination process according to ADA implementing regulations (i.e., CFR Parts 37 and 38). I also agree to provide all evidence or documentation deemed necessary by Zip for a final eligibility determination for Paratransit demand response transportation service or a subsequent appeal.

I certify that the statements I have made herein are true and correct and understand that false or fraudulent statements and certifications are punishable by law under 18 U.S.C. Subsection 10001 (1982).

Signature_______________________________________ **Date** ___________________

Name (please print) ____

Address ____

City ______________________________ State _____________ Zip Code _________

Office Telephone Number ________________Fax: ______________________________

Licensing Identification# ____

FOR OFFICE USE ONLY:

New Application ❑Yes ❑No   Recertification ❑Yes ❑No

Applicant's Name: ____

Applicant's Address: ____

Determination: ____ADA NO.______________

Expiration Date: ______/_______/______

Assessment Date: ______/_______/______

Interview Date: ______/______/______

Interviewed By: ______________________ Date: ______/_______/______

Approved By: ________________________ Date: ______/_______/______

Status: ____

Eligibility Category: ____

Temporary ❑Yes No Duration(months): ________________

Client's ID: ___________________________

Comments: ____

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FOR APPEAL USE ONLY:

DATE CONTACTED:

_____/_____/_____ BY: _________________________________

APPEAL DATE: _____/_____/_____

DETERMINATION: