

**APPLICATION FORM**

**ADA PARA EXPRESS ELIGIBILITY**

This application will be used solely to determine ADA eligibility for the Para Express and Friendly Bus. Please complete this application to the best of your ability. The information on this application will be confidential and will only be released with your permission.

*Please use the back of the application if you need additional space.*

PLEASE PRINT OR TYPE:

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT. \_\_\_\_\_

CITY OR TOWN: \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE (Home): \_\_\_\_\_ (Work): \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ MEDICAID NUMBER: \_\_\_\_\_

Please give us the name and telephone number of someone we can call in the event of an emergency.

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Type of Eligibility:     Conditional Temporary     Conditional Permanent

Unconditional Temporary     Unconditional Permanent

**1) Do you have a disability, which prevents you from using the City Express fixed-route bus service?**     Yes     No

If yes, please describe all physical, mental, visual, or functional disabilities which prevent you from using City Express fixed-route bus services.

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2) Is this condition temporary? \_\_\_\_\_

3) If yes, what is the expected duration? \_\_\_\_\_

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4) Do you have a visual impairment?  Yes  No  Sometimes

If yes or sometimes, please explain:

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5) Please check the following descriptions which best apply to your disability:

	I can not	Sometimes	I have no Difficulty
Using Stairs	_____	_____	_____
Riding Buses	_____	_____	_____
Reading Informational Signs	_____	_____	_____
Standing in a Moving Vehicle	_____	_____	_____
Hearing Spoken Directions or Announcements	_____	_____	_____
Processing Spoken Directions or Announcements	_____	_____	_____
Walking $\frac{3}{4}$ mile	_____	_____	_____

If sometimes, please explain: \_\_\_\_\_

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6) Do you use any of the following mobility aids? (Check all that apply) This information is not used to determine paratransit eligibility, but rather to help us to better understand your needs and assist you.

Manual Wheelchair \_\_\_\_\_ Electric Wheelchair \_\_\_\_\_ Powered Scooter \_\_\_\_\_

How wide is it? \_\_\_\_\_ inches

How heavy is it when occupied? \_\_\_\_\_ pounds

The Americans with Disabilities Act of 1990 defines a wheelchair as a mobility aid belonging to any class of three- or more-wheeled devices, usable indoors, designed or modified for and used by individuals with mobility impairments, whether operated manually or powered.

Prosthetic Device and/or Brace \_\_\_\_\_ Cane \_\_\_\_\_ Crutches \_\_\_\_\_

Walker \_\_\_\_\_ Service Animal \_\_\_\_\_ Segway \_\_\_\_\_

7) Do you need to travel with someone who will assist you with your trip?  
Always \_\_\_\_\_ Sometimes \_\_\_\_\_ Never \_\_\_\_\_

8) Do you currently use the City Express service? \_\_\_\_\_ Yes \_\_\_\_\_ No

9) Have you ever received mobility / travel training? \_\_\_\_\_ Yes \_\_\_\_\_ No

If not would you consider participating in this training? \_\_\_\_\_ Yes \_\_\_\_\_ No

10) Are you able to locate fixed-route bus stops, destinations, locations, or cross streets independently?     Yes     No     Sometimes

If no or sometimes, please explain: \_\_\_\_\_  
\_\_\_\_\_

11) Are you able to wait outside without assistance or support for ten (10) minutes?  
 Yes     No     Sometimes

If no or sometimes, please explain: \_\_\_\_\_  
\_\_\_\_\_

12) Are you able to wait longer than 15 minutes?     Yes  No     Sometimes  
If so, how long can you wait? \_\_\_\_\_ minutes

13) What is the closest bus stop to your house? (Location of stop) \_\_\_\_\_  
\_\_\_\_\_

14) Please use this space to tell us anything else you would like us to know about your travel challenges: \_\_\_\_\_

I, as the applicant, understand that in order to be eligible to use ADA Para Express service, I must have a disability which makes me unable to use the City Express fixed route service.

I agree to notify Home Healthcare Hospice and Community Services of any changes in the status of my disability that affects my ability to use complementary paratransit service. I understand that providing false information in this application could result in a loss of ADA paratransit service as well as a penalty under the law.

**I hereby certify that I am the individual requesting certification for ADA complementary paratransit service and that all information contained in this application is true and accurate:**

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

If this application is being filled out by someone other than the person requesting certification, please complete the following:

Name \_\_\_\_\_

Relationship to applicant \_\_\_\_\_

Phone # \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_