Application for ADA Paratransit Service

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 specialist about your condition and abilities

For:
Large Print
Compact Disc/CDR
Electronic Mail

Call: (415) 351-7000

Если вы хотите иметь это заявление на русском языке, пожалуйста, позвоните по телефону (415) 351-7006

Si usted desea tener esta solicitud en español, por favor llame al (415) 351-7004

如果您想使用中文申請, 請致電 (415) 351-7005

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, medical verification, or an in-person interview. The in-person interview may include a functional test to determine your ability to take a public transit trip, such as being capable of walking to a bus stop, reading signs etc.

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.

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 two places to complete the application:**

   - Applicant Certification (Page 8)
   - Authorization for Use or Release of Medical Information from an appropriate medical or rehabilitation professional (Page 9)

4. **Return the completed application to:**
   Mail: 68 – 12th Street, San Francisco, CA 94103
   Fax: (415) 351-3135
   Email: sfptcertification@sfparatransit.com

For help with the application process or to check on the status of your application, please call: (415) 351-7050.

Thank you

Personal Contact Information
(Please Print)

Required:
Name *(first, middle, last):*
_____ **Birth Date:** ____/____/_____

Home Address: _____ Apt. #: _____

City: _____ Zip: _____

Mailing Address *(if different from home):*
_____ Apt. #: _____

City: _____ Zip: _____

Primary Phone: (_____) _____ select one ☐home ☐work ☐cell

Optional:
Secondary Phone: (_____) _____ select one ☐home ☐work ☐cell

E-Mail: _____ **Gender**: ☐ Female ☐ Male ☐ Other _____

Clipper Card Number: _____ **Paratransit ID#** *(if known)* _____

Preferred Language*:* ☐ English ☐ Other *(specify)* _____

Race/Ethnicity: ☐ Asian or Asian American ☐ Black and/or African American
☐ Hispanic and/or Latina/o/x ☐ Middle Eastern and/or North African
☐ White or Caucasian ☐ American Indian or Alaska Native or Indigenous
☐ Native Hawaiian or Pacific Islander ☐ Not listed (specify): _____
☐ Prefer Not to State

If you need any future written information provided to you in an accessible format, please check which format you prefer*:*

☐ Large Print ☐ E-mail (for TTS reader) ☐ Braille
☐ Other _____

In case of emergency, whom should we contact?
Name: _____

Relationship: _____

Primary Phone: (____) _____Secondary Phone: (____) _____

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. Which **disability or health related conditions <u>PREVENT</u>** you from using regular public transit without the help of another person (i.e. BART, bus, 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.
   ☐ Don't know.

5. Are the conditions you described:
   ☐ Permanent ☐ Temporary ☐ Don't Know
   If temporary, how long do you expect this to continue?

_____

Tell Us About Your Capabilities and Usual Activities

6. Do you currently use any of the following mobility aids or specialized equipment? *(Check all that apply):*

☐ Cane ☐ White Cane ☐ Walker
☐ Crutches ☐ Leg Braces ☐ Portable Oxygen Tank
☐ Service Animal ☐ Power Scooter ☐ Power Wheelchair
☐ Manual Wheelchair
Can you transfer from your manual wheelchair into a seat? ☐ Yes ☐ No
☐ Other Aid _____

7. Please check the box that best describes your current living situation:

☐ 24hour care or Skilled Nursing Facility
☐ Assisted Living Facility
☐ Memory Care Facility *(select one)*: ☐ Basic ☐ Advanced
☐ 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)

8. How many city blocks can you travel with your usual mobility aid and without the help 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 your use of regular public transit (for example, Muni bus or rail)?
(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
☐ TNC / Ride Share
☐ 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 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:

_____

_____

17. Please add any other information that you would like us to know about your ability to use regular public transit.

_____

_____

_____

_____

_____

Have you answered all the questions and provided explanations where required?

You must provide SIGNATURES in two places to complete the application:

- Applicant Certification (Page 8)
- Authorization for Use or Release of Medical Information from an appropriate medical or rehabilitation professional (Page 9)

INCOMPLETE APPLICATIONS WILL BE RETURNED.

Applicant Certification

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 it may be necessary to contact a professional familiar with my functional abilities to use public transit in order to assist in the determination of eligibility.

Sign here:

Applicant's signature _____ Date _____

Is there someone (e.g., relative, social worker or agency, etc.) that you would like us to notify 90 days before your eligibility expires?

☐ Yes ☐ No

If yes, Person's Name/Agency:

_____

Email address: _____ Phone: (____) _____

Relationship: _____

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.

Continue to Page 9 to sign Authorization to Medical Release Information

Authorization for Use or Release of Medical Information

(To be filled out by Applicant or Applicant's representative)

Please provide the Physician or Provider who best understands the Applicant's functional abilities to use public transportation.

Applicant's Physician or Provider: _____

Physician Address: _____

Physician Telephone: _____ Fax: _____

Medical Record or ID #, if known: _____

I, the Applicant, hereby authorize the use or disclosure of my individually identifiable Protected Health Information (PHI) as described below in this form to Transdev/SF Paratransit for purposes of determining my eligibility to receive transportation services.

Applicant's Name: _____

Please send requested information to:

San Francisco Paratransit, 68 - 12th Street, San Francisco, CA 94103

Specific description of Protected Health Information (PHI) to be used or disclosed:

Any documented disabilities of the Applicant and how their disability or disabilities affect the Applicant's ability to independently use Muni or BART's otherwise accessible buses/trains.

This Authorization expires one (1) year from the date of signature, OR upon occurrence of the following event: SF Paratransit's receipt of the PHI requested, which allows SF Paratransit to make an ADA Paratransit eligibility determination.

I understand that the PHI used or disclosed may be subject to redisclosure by the entity receiving it, and would then no longer be protected by federal privacy regulations. I also understand that I may revoke this Authorization at any time by notifying SF Paratransit in writing.

(Form MUST be completed before signing)

SIGN

_____ _____

Signature of Applicant or Applicant's representative Date

If applicable, printed name of Applicant's representative: _____

Relationship to the Applicant: _____

(This form is available in accessible formats and/or alternative languages upon request.)