FIRST CAPITAL TROLLEY

PARATRANSIT ELIGIBILITY APPLICATION

January 2015

First Capital Trolley a public transportation system, provides fixed route service to all of the citizens of Logan County. **Every bus** is equipped with a lift or ramp for those passengers that can not negotiate the steps on the buses. First Capital Trolley also offers a Paratransit service, which provides **curb-to-curb** service (as modified by FTA guidance for origin to destination for individuals who can not use fixed-route service to make their trips). The Paratransit service area complements the fixed route system and utilized guidelines established to be eligible for this service, functional limitations of an individual's disability must prevent use of a regular fixed-route service. Age, and inability to drive by themselves, are not taken into consideration in determining eligibility. While your doctor's verification of need is required for application, the final determination of eligibility will be made by the Paratransit ADA Certification.

Eligibility for use of Paratransit Services is determined by review of application and verification provided by Health Care Specialist.

Use of the First Capital Trolley Paratransit service is based on the service area, which can be found online at www.firstcapitaltrolley.com

Applicants for Paratransit service should complete Section I, Parts A through C. They should then provide their physician with Part D, to be completed by them and returned to applicant.

If you are able to use the fixed route bus system, but wish to apply for a disability card to receive reduced fares and priority seating, please complete the Disability card eligibility application in Part E.

Parts A through D, ***along with a photocopy of a picture ID***, should be returned to:

First Capital Trolley
C/O ADA Certification
Post Office Box 1512
Guthrie, Oklahoma 73044

The application must be filled out completely or it will not be processed!
Please type or fill out in blue or black ink.

Section I, Part A Contact Information
To be completed by, or for, the applicant

Last Name:_____ **First Name**:_____ **Middle Initial**:_____

Home Address: _____
(Street)

_____ _____ **Home Phone**: (____)_____
(City) (Zip)

Business Address: _____

_____ _____ **Business Phone**: (____)_____
(City) (Zip)

Date of Birth: _____ **Sex**: ☐ Male ☐ Female
(dd/mm/yr)

Emergency Contact _____ **Phone Number** _____

Do you use a Primary Care Attendant (PCA) ? Yes ☐ No ☐

Communication method: ☐Speak independently ☐ Communication Device ☐ Sign Language ☐ Writing ☐ Other _____

Aids: ☐None ☐Wheelchair ☐ Crutches ☐Walker ☐Power wheelchair ☐ Scooter ☐ White Cane ☐Service animal ☐ Oxygen tank ☐ Other _____

_____

Type of service expected to use: ☐ Fixed route (regular service) ☐ Paratransit

Does your disability require you to have assistance from the door of the bus to the door of your origin or destination? ☐ Yes ☐ No

(Copy PART A to Transit Office)

Section I, Part B Self Evaluation
To be completed by, or for, the applicant

Please answer the following questions. If you need help filling out the application, please call (405) 282-6000 Monday thru Friday from 8:00 am until 4:00 pm for assistance. Your answers to these questions in this section will help us better understand your functional ability in specific areas.

1. Physician's Name: _____

Physician's Address: _____
(Street)

_____ _____ **Physician's Phone**: (___)_____
(City) (Zip)

2. Physician's Name (if applicable): _____

Physician's Address: _____
(Street)

_____ _____ **Physician's Phone**: (___)_____
(City) (Zip)

Disability description: _____

_____

1. **Please describe how your disability prevents you from using the regular fixed route bus system:**

_____

_____

_____

_____

2. **Is your disability temporary** ☐ Yes ☐ No

3. **Do you currently use First Capital Trolley fixed route bus service?** ☐Yes ☐ No

4. **Have you had your disability for more than one year?** ☐ Yes ☐ No

5. **How far can you walk without assistance? (If you use a wheelchair or other mobility device, how far can you travel using that device?)**_____

6. **Does your disability change from day to day in a way that prevents you from using the regular buses?**

   ☐ YES, my condition is good on some days and bad on other days.

   ☐ NO, my condition doesn't change much from one day to another.

If you answered YES on question 6, answer the next two questions, otherwise, skip to question 7.

A. On a day when my condition is GOOD, (choose ONE):

   a. ☐ I can't travel outside my house
   b. ☐ I can get to the curb in front of my house
   c. ☐ I can travel 1 block
   d. ☐ I can travel 2 blocks
   e. ☐ I can travel 4 blocks (1/4 mile)
   f. ☐ I can travel 6 blocks (1/2 mile)

B. On a day when my condition is BAD, (choose ONE):

   a. ☐ I can't travel outside my house
   b. ☐ I can get to the curb in front of my house
   c. ☐ I can travel 1 block
   d. ☐ I can travel 2 blocks
   e. ☐ I can travel 4 blocks (1/4 mile)
   f. ☐ I can travel 6 blocks (1/2 mile)

7. **Does the weather ever keep you from using fixed route bus service?**

   ☐ Yes (describe what kind and how this keeps you from using fixed route bus service) : _____

   _____

   ☐ No

8. **If you use a manual wheelchair, please list your weight & the weight of the chair.**
   Your weight _____ Wheelchair weight _____

9. **If you use a Personal Care Assistant (PCA), check all that apply.**
   The PCA helps me:
   - ☐ get to the bus stop
   - ☐ get on and off the bus
   - ☐ while I ride the bus
   - ☐ get where I am going once I am off the bus
   - ☐ other :_____

10. **Which of the following limits your ability to use the fixed route buses? (check all that apply)**

    ☐ physical disability

    ☐ visual impairment/blindness

    ☐ cognitive disability

    Please describe why this limits your ability to use the fixed route buses:

    _____

    _____

11. **How are your transportation needs being met now? Please check all that apply.**

    ☐ walking

    ☐ personal transportation (car)

    ☐ public transportation (bus, taxi)

    ☐ agency-sponsored rides (who?) _____

    ☐ Paratransit service (who?) _____

    ☐ ambulance (who?) _____

    ☐ friend/ relative

    ☐ other _____

12. **Most of the time can you:**

    Cross the street, if there are curb cuts?
    ☐ Always ☐ Sometimes ☐ Never ☐ Not sure

    Cross a 2 lane street?
    ☐ Always ☐ Sometimes ☐ Never ☐ Not sure

Cross a 4 lane highway with stop lights?
☐ Always ☐ Sometimes ☐ Never ☐ Not sure

Go up and down hilly terrain
☐ Always ☐ Sometimes ☐ Never ☐ Not sure

Tolerate temperature extremes (hot/cold)
☐ Always ☐ Sometimes ☐ Never ☐ Not sure

Locate signs at night
☐ Always ☐ Sometimes ☐ Never ☐ Not sure

13. Are you able to perform the following functions without assistance?

Find your way between familiar locations ☐ Yes ☐ No
Signal a bus driver to get off at familiar stop ☐ Yes ☐ No
Grasp coins, passes and handles ☐ Yes ☐ No
Communicate addresses, destinations, and telephone numbers ☐ Yes ☐ No
Ask for, understand, and follow directions ☐ Yes ☐ No
Deal with unexpected situations or changes in routine ☐ Yes ☐ No
Recognize a destination or landmark ☐ Yes ☐ No

14. Can you wait 10 to 15 minutes at a bus stop?

☐ Yes, always
☐ Yes, sometimes
☐ No, I can only wait _____ minutes
☐ I don't know

15. Have you ever had training using a fixed route bus service?

☐ Yes ☐ No
If yes, who trained you? _____

16. List three locations where you would like to have training on using the fixed route bus:

_____

_____

_____

17. Please list your most frequent trips and how you get there now

a. Origin : _____ Round trip? _____

Destination? _____ How often? _____

Address: _____

_____ _____
(City) (Zip)

☐ by First Capital Trolley ☐ Other _____

b. Origin : _____ Round trip? _____

Destination? _____ How often? _____

Address: _____

_____ _____
(City) (Zip)

☐ by First Capital Trolley ☐ Other _____

Section I, *Part C Applicant Certification*
To be completed by, or for, the applicant

I understand that the purpose of this application is to determine if I am eligible for ADA Paratransit services. First Capital Trolley or its contracted agents may need to talk to me or to see me at another time for an in-person interview and/or functional assessment to complete the application process. I understand that I must be truthful in answering the questions in this form and at my in-person assessment, if required. Giving false information is against the law and may result in loss of Paratransit service and/or criminal penalties. I agree to notify First Capital Trolley if I am no longer eligible for Paratransit service.

I authorize my physician, health care provider, trainer, specialist to discuss my diagnosis, treatment plan, medications, and/or prognosis for the purpose of determining my ability to use accessible First Capital Trolley buses.

I certify that the information in this application is true to the best of my knowledge. I understand if First Capital Trolley or its authorized agents receive information regarding change in my functional mobility, my eligibility status may be reviewed and changed. I understand that First Capital Trolley or one of its contracted agents will notify me of any change in my eligibility status and I may appeal such decision within sixty (60) days of notification.

_____ _____ _____
(Applicant's Name, printed) (Applicant's Signature) (Date)

☐ **Copy of Applicant ID Card included**

To be filled out if the applicant was helped by another person in completion of this application:

Name: _____ Phone: _____

Address: _____

Relationship with applicant: _____

_____ _____
(Signature) **(Date)**

<u>The following Section (Part D) is to be filled out by a Health Care Professional. Failure to have this section completely filled out by the Health Care Professional will result in delay in processing of application.</u>

Section I, Part D Professional Verification
to be filled out by Health Care Professional

Dear Health Care Professional:

You are being asked by _____ to provide information
(applicant)
regarding their ability to use our transit system. Federal law requires that First Capital Trolley provide Paratransit services to persons who can not use fixed-route transit services. The information you provide will allow us to evaluate this request and its application to specific trip requests. Certification to use this service will not be based solely on your verification in this document. Thank you for your cooperation in this matter.

To qualify for Paratransit services, a person must be unable to use regular public transit due to physical or cognitive disability. Individuals qualify if:

1. as the result of their disability, they cannot board, ride, or disembark a First Capital Trolley fixed route bus (all fixed route buses are lift-equipped); or
2. they have a specific impairment-related condition which prevents them from getting to/ from a bus stop.

PLEASE NOTE: This does not include persons who find it uncomfortable, inconvenient, or difficult to get to and from bus stops.

Resources for this program are limited and your evaluation of each person must be based solely upon the individual's ability to use regular transit. Your verification should consider only presence of a disabling condition, not the applicant's age or economic status. Please exercise care in evaluating applicants for this program. Evaluation is based on federal guidelines and are used for establishing paratransit accessibility. The determination will be applicable for use on any of the nation's ADA compliant paratransit services.

CERTIFICATION PROCESS

1. Applicant has completed Parts A through C.
2. Health Care Professional completing Part D must be guided by criteria explained herein.
3. First Capital Trolley or its authorized agents may contact the certifying health care professional to verify accuracy of the information.
4. First Capital Trolley's certification agent will make the final determination of the applicant's eligibility.
5. The application must be filled out COMPLETELY for processing to occur.
6. All applicants will receive their eligibility determination in writing for First Capital Trolley.

First Capital Trolley is a limited special transportation service for disabled persons who, because of cognitive or physical disability, find it IMPOSSIBLE to use regular public transportation. All parts must be completely filled out by the authorized person who signs below. Incomplete forms will be returned to the applicant.

A. Indicate nature of applicant's disability (check as many as may apply):

☐ Non-ambulatory (uses wheelchair for mobility)
☐ Impaired or assisted ambulatory requiring special mobility aid _____
☐ Arthritis/Osteoarthritis (specify extremity) _____
☐ Amputation (specify extremity) _____
☐ Cerebrovascular Accident
☐ Pulmonary Ills (does applicant require portable Oxygen Yes ☐ No ☐
☐ Neurological Impairment
☐ Cardiac Ills
☐ Kidney disease/dialysis
☐ Sight disability Legally blind ☐ Visually impaired ☐
☐ Incoordination
☐ Mental Retardation Moderate ☐ Severe ☐ Profound ☐
☐ Cerebral Palsy
☐ Autism
☐ Severe Muscle Spasms
☐ Seizures
☐ Loss of consciousness
☐ Mental illness (specify what it is about cognitive disability that limits use of regular bus service) _____
_____

☐ Other _____
_____

Describe type and severity of disability in detail and how it prevents use of transit:
_____
_____
_____

B. The disability is: Permanent ☐ Temporary ☐
If temporary, expected duration is _____

In your opinion, must this individual bring a competent attendant on each trip?
Yes ☐ No ☐

If applicant is visually impaired or blind, developmentally disabled, suffers from neurological impairment or is mentally limited, has applicant ability to receive training in fixed route buses? Yes ☐ No ☐

How far can the applicant walk unassisted? (If applicant uses a wheelchair or other mobility device, how far can the applicant travel using that device?):
☐ 1 block
☐ 2 blocks
☐ 4 blocks (1/4 mi)
☐ No limitation

* Other _____

Is there any other effect of the disability of which First Capital Trolley should be aware? Please provide an explanation. _____
_____
_____
_____

C. Is the applicant on any medication which might have an impact on ability to use public transportation ☐ Yes ☐ No Explain _____
_____
_____

D. Your professional area of specialization is:

☐ Family Physician
☐ Cardiologist
☐ Podiatrist
☐ Optometrist
☐Audiologist
☐ Psychologist
☐ Physical Therapist
☐ Rehabilitation Specialist
☐ Independent Living Specialist
☐ Registered Nurse/LPN
☐ Other _____

HEALTH CARE PROFESSIONAL CONTACT INFORMATION

Name: _____

Title: _____ **Agency/Company Name**: _____

Professional License # (if applicable): _____

Office Address: _____
(Street)
_____ _____ **Office Phone Number:** (____)_____
(City) (Zip)

I hereby certify that the above information is true. First Capital Trolley will make the final determination on the applicant's eligibility for First Capital Trolley Paratransit service.

_____ _____

(Signature) (Date)

THANK YOU FOR YOUR ASSISTANCE IN PROCESSING THIS APPLICATION!

Section II, Disability Certification Card Application (Fixed Route Only)

Contact Information

To be completed by, or for, the applicant

Last Name:_____ **First Name**:_____ **Middle Initia**l:____

Home Address: _____
(Street)

_____ _____ **Home Phone**: (___)_____
(City) (Zip)

Business Address: _____

_____ _____ **Business Phone**: (___)_____
(City) (Zip)

Date of Birth: _____**Sex**: ☐ Male ☐ Female
(dd/mm/yr)

Do you use a Primary Care Attendant (PCA) ? Yes ☐ No ☐

Physician/Evaluator's Name:_____

Physician/Evaluator's Address: _____
(Street)

_____ _____ **Physician/Evaluator's Phone**: (___)_____
(City) (Zip)

Disability description:_____

_____

Communication method: ☐Speak independently ☐ Communication Device ☐ Sign Language ☐ Writing ☐ Other _____

Aids: ☐None ☐Wheelchair ☐ Crutches ☐Walker ☐Power wheelchair ☐ Scooter ☐ Cane ☐Service animal ☐ Oxygen tank ☐ Other _____

_____

Please attach documentation of your disability from a qualified professional. Acceptable forms of documentation include:

- Documentation from a physician regarding a medical or developmental disability.
- Report from a psychologist/diagnostician/psychiatrist regarding mental illness or learning disability.
- Audiologist report regarding deafness or hearing impairment.
- Ophthalmologist report regarding visual impairment.

Mail completed application to:

First Capital Trolley
C/O ADA Certification
Post Office Box 1512
Guthrie, Oklahoma 73044

All Paratransit application forms and user guides are available in computer disk, large print, audio, or braille upon request.