



## Paratransit Services Application

Upon request, alternative formats of this information will be produced for people with disabilities. Please call (509) 325-6094 or TTY (509) 232-6556.

If the effects of your disability **prevent** you from getting to a bus stop, riding a lift- or ramp equipped bus, and/or getting off the bus and getting to your destination, you may be eligible for Spokane Transit Paratransit Services. Eligibility determinations are made based upon the limitations caused by your disability(ies) and will be tailored to your abilities. You may qualify for partial or full service.

**Age, being new to Spokane, never having ridden the bus, the inability to carry packages, and the inability to drive are not disabilities. They will not qualify you to ride Paratransit.**

To apply:

- Fill out Sections 1 through 5 of the enclosed application form or have someone assist you with filling it out.
  - Sign your application in ink on page 6 after reading the Applicant Agreement and Release of Information.
  - Have Part 6 - Professional Verification - completed and signed by a licensed medical or mental health professional. (See list at top of page 7.)
  - Return the completed application form to Spokane Transit.
  - Spokane Transit may need specific information about the effects of your disability. You may be asked to provide additional information and/or participate in a physical or cognitive functional assessment.
- Your application will not be considered complete until all requested information is provided to Spokane Transit.**

This form has 8 pages. Please be sure that **all** sections have been completed before returning the form to Spokane Transit. Incomplete information will delay the processing of your application.

The information you provide will be used to determine your eligibility for Paratransit Services. Spokane Transit will process your application and notify you within 21 days after your **completed application** has arrived in our office. If you are found eligible for Paratransit Services, you must be able to meet the Van Operator at the main building entrance of your origin and your destination.

If you have any questions or need assistance in completing this application, please call (509) 325-6052 or TTY (509) 232-6556.



# PARATRANSIT SERVICES APPLICATION

<input type="checkbox"/>	New
<input type="checkbox"/>	Recertification
ID # _____	

It is important that *all* parts of this application are completed. An incomplete application will be returned to you, causing a delay in processing.

PLEASE PRINT CLEARLY

Last Name \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_

Mailing Address \_\_\_\_\_ Apt./Sp. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Pick-Up Address \_\_\_\_\_ Apt./Sp. # \_\_\_\_\_  
(If different from mailing address)

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Complete only if Paratransit Certificate of Eligibility card is to be sent to a different mailing address.**

Recipient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Date of Birth (month/day/year) \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female

Daytime Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

TTY Phone \_\_\_\_\_ (Text telephone for the hearing impaired)

**Language Ability:**

English  Other (specify) \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Cell \_\_\_\_\_

## Part 1: ADA Eligibility Information

A. Can you ride the regular bus without someone else's help?

Yes     No     Sometimes

B. What is (are) your limiting disability(ies)?

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C. Does your disability *prevent* you from riding the regular bus service?

Yes     No     Sometimes

If yes or sometimes, explain how your disability prevents you from riding the regular bus: \_\_\_\_\_

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D. Is your need for Paratransit van service long term or temporary?

Long term     Temporary - Until when? \_\_\_\_\_

E. Do your limitations change from time to time because of medical treatments, medications or for other reasons?

No     Yes - How? \_\_\_\_\_

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F. Because of your disability(ies), do weather conditions (such as heat, cold, rain, snow or ice) prevent you from using a regular bus without someone's help?

No     Yes - How? \_\_\_\_\_

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G. Because of your disability(ies), do terrain conditions (such as hills, uneven surfaces, or curbs) prevent you from using the regular bus without someone's help?

No     Yes - How \_\_\_\_\_

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**H. How far can you walk (unsupervised and with the use of a mobility aid if needed) in the community without someone's help?** If you use a wheelchair, skip this question.

- |                                   |  |
|-----------------------------------|--|
| <input type="checkbox"/> 3/4 mile | <input type="checkbox"/> 2 blocks                      |
| <input type="checkbox"/> 1/2 mile | <input type="checkbox"/> 1 block                       |
| <input type="checkbox"/> 1/4 mile | <input type="checkbox"/> Less than 1 block             |
| <input type="checkbox"/> 3 blocks | <input type="checkbox"/> Not able to walk any distance |

**I. How far is your residence from the nearest bus stop?** (For bus stop information, call 328-7433.)

- |  |   |
|--|---|
| <input type="checkbox"/> Less than 1 block | <input type="checkbox"/> 1/4 mile       |
| <input type="checkbox"/> 1 block           | <input type="checkbox"/> 1/2 mile       |
| <input type="checkbox"/> 2 blocks          | <input type="checkbox"/> 3/4 mile       |
| <input type="checkbox"/> 3 blocks          | <input type="checkbox"/> 1 mile or more |

**J. How many stairs can you go up or down without someone's help?**

- |   |                                  |                               |
|---|----------------------------------|-------------------------------|
| <input type="checkbox"/> 2 or more stairs | <input type="checkbox"/> 1 stair | <input type="checkbox"/> none |
|---|----------------------------------|-------------------------------|

**K. Do you now ride or have you ever ridden the regular bus without someone's help?**

**Yes** - When? \_\_\_\_\_

Where? \_\_\_\_\_

How Often? \_\_\_\_\_

Why did you stop riding? \_\_\_\_\_

\_\_\_\_\_

**No** - Please explain why: \_\_\_\_\_

**L. Would you be interested in learning how to use the regular bus?**

**Yes**       **No** - Please explain: \_\_\_\_\_

If you indicated yes,  
a mobility trainer will  
contact you soon.

\_\_\_\_\_  
\_\_\_\_\_

## Part 2: Functional Abilities

### A. Please answer the following questions:

**Yes**      **No**      **Sometimes**

- |                          |                          |                          |   |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Can you ask for, understand and follow directions?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Can you cope with unexpected problems or changes in your routine?                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Can you recognize landmarks?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Can you tell time?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Can you cross a busy street at the crosswalk?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Can you <b>see</b> well enough to walk or travel to a bus stop?                                   |
|                          |                          |                          | <input type="checkbox"/> Always <input type="checkbox"/> Daylight only - Please explain:<br>_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Can you use a telephone to make and receive calls?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Can you transfer from one bus to another?   |

If you checked "Sometimes" on any item, please explain: \_\_\_\_\_

### B. Do you use a service animal to assist you?

Yes     No     Sometimes    Kind of animal \_\_\_\_\_

### C. Do you travel with portable oxygen?

Yes     No     Sometimes

### D. Will you need to bring your helper (Personal Care Attendant - PCA) with you?

Yes     No     Sometimes

### E. Will you need to use the lift to board the van?

Yes     No     Sometimes

### F. Can you find your way to/from the regular bus stop without someone's help?

Yes     No    **Check all that apply**

- I get confused or can't remember where I'm going.  
 I need someone to help me get to and from the bus stop.  
 I need someone to help me transfer to another bus.  
 Other: \_\_\_\_\_

### Part 3: Mobility Aids

**A. When traveling in the community, what mobility aids/equipment do you use?**

I do not use any aids or equipment. (If no aid is used skip to Question F.)

white cane

motorized wheelchair

cane/crutches

scooter

walker

manual wheelchair

braces

Other (please specify) \_\_\_\_\_

**If you checked more than one box, explain when/how you use them:**

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**B. If you use a walker, does it fold?**  Yes  No

**C. If you use a wheelchair or a scooter, is it more than 30-inches wide, 48-inches long, or is the combined weight of chair and occupant more than 600 pounds?**

Yes Specify dimensions/weight: \_\_\_\_\_

No

**D. If you use a manual wheelchair, are you able to self-propel?**

Yes How far? \_\_\_\_\_ Comments: \_\_\_\_\_

No Please explain: \_\_\_\_\_

**E. If you use a wheelchair, how far are you able to travel unsupervised?**

3/4 mile

2 blocks

1/2 mile

1 block

1/4 mile

Less than 1 block

3 blocks

Not able to travel any distance

**F. Is there any additional information regarding your condition or travel restrictions that has not been addressed?**

## Part 4: Representative

If a person other than the applicant filled out this application, please complete the following (please print):

Name \_\_\_\_\_ Daytime Phone # \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_ Agency \_\_\_\_\_

## Part 5: Paratransit Services Applicant Agreement & Authorization for Release of Information

**By signing below, you authorize the release of verification information and any other information to Spokane Transit or its representatives for the purpose of evaluating your eligibility to receive paratransit service.**

Please be advised that Spokane Transit will use your statements to determine your eligibility for benefits as provided by law. The statements contained herein are material to Spokane Transit's determination and Spokane Transit may act in reliance thereon.

Providing false information is punishable by fine or imprisonment (RCW 9A-72.085 and RCW 40.16.030). STA may share your eligibility determination with other transportation providers, on request, to facilitate travel in Spokane and other transit districts.

This form must be signed by the Applicant or by the individual who has designated Power of Attorney, or is a Legal Guardian for the Applicant. If the Applicant is under 18 years of age, a parent or Legal Guardian must sign this form. If the applicant is over 18 years old and you are signing as a Power of Attorney or Legal Guardian, please include a copy of the authorizing document.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Applicant       Designated Power of Attorney       Legal Guardian

**I hereby certify under the penalty of perjury under the laws of the State of Washington that the information provided on this application is true and correct.**

**A licensed medical or mental health professional who is familiar with you and your disability must complete the remaining questions on pages 7 and 8 of this application.** If you have been told there is a charge for obtaining medical or mental health verification, call (509) 325-6052. Spokane Transit may be able to identify an alternative service that does not charge for the required verification.

**For the purpose of this application, licensed medical or mental health professionals are limited to:** Medical Doctor (MD or DO), Optometrist, Psychologist (Ph.D.), Physician Assistant, Chiropractor, Clinical Social Worker, Nurse Practitioner, Recreational, Physical or Occupational Therapist, Certified Orientation & Mobility Specialist, or MDS Nurse (skilled nursing facility only).

Applicant's Name \_\_\_\_\_

## Part 6: Licensed Medical or Mental Health Professional Verification

Please check one:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Medical Doctor (MD or DO)                 | <input type="checkbox"/> Optometrist                                      | <input type="checkbox"/> Psychologist (Ph.D.)   |
| <input type="checkbox"/> Physician Assistant                       | <input type="checkbox"/> Chiropractor                                     | <input type="checkbox"/> Clinical Social Worker |
| <input type="checkbox"/> Nurse Practitioner                        | <input type="checkbox"/> Recreational, Physical or Occupational Therapist |   |
| <input type="checkbox"/> MDS Nurse (Skilled Nursing Facility only) | <input type="checkbox"/> Certified Orientation & Mobility Specialist      |   |

**INSTRUCTIONS: This individual is applying for Spokane Transit Paratransit Services.** In accordance with the Americans with Disabilities Act of 1990, paratransit service is available only for persons who, because of a disability, are **prevented** from taking the regular fixed route bus. All Spokane Transit buses are equipped with lifts for people who cannot climb stairs. The individual could be prevented in either of the following ways: 1) is unable to *independently* get to and from a bus stop, on or off the bus or successfully navigate to a destination, or 2) is unable to understand how to complete a bus trip.

**For the benefit of the Applicant, please answer the following questions as fully and accurately as possible. Please be specific when answering the questions. Incomplete answers will result in the application being returned to the applicant. All health care information will be kept confidential.** Please call (509) 325-6052 if you have any questions. Thank you for your time and cooperation.

Please review the information contained in Parts 1 through 3, as provided by the Applicant or Applicant's representative.

1. Based on your knowledge of the Applicant's condition, is the information provided accurate?

- Yes     No     Somewhat

If you checked "no" or "somewhat" please explain: \_\_\_\_\_

2. What specific conditions contribute to the Applicant's mobility and/or cognitive limitations? Please define the degree of impairment. (Include measures of visual or hearing acuity, GAF or IQ scores, if applicable.)

**NOTE: Age, the inability to drive or the inability to carry packages are *not* qualifying factors.**

DIAGNOSIS/DISABILITY	DEGREE OF IMPAIRMENT	DATE OF ONSET (If known)
_____	/ _____ / _____	/ _____ / _____
_____	/ _____ / _____	/ _____ / _____
_____	/ _____ / _____	/ _____ / _____
_____	/ _____ / _____	/ _____ / _____
_____	/ _____ / _____	/ _____ / _____

3. The disability that prevents the Applicant from accessing the regular bus system is:

Chronic     Acute - Until \_\_\_\_\_

4. Applicant's need for Paratransit service is:

Long term     Temporary - Until \_\_\_\_\_

5. Are any of these conditions episodic or variable in their severity?

No     Yes - if yes, please give details:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Please provide any additional information that you deem relevant as to why this Applicant cannot use regular bus service:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I HEREBY CERTIFY** under penalty of perjury under the laws of the State of Washington that the information provided on the Professional Verification portion of this application is true and correct.

\_\_\_\_\_  
**Licensed Professional's Signature**

\_\_\_\_\_  
**Specialty**

\_\_\_\_\_  
**Date**

Printed Name: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Would you like additional information regarding Paratransit Services and eligibility criteria?

Yes     No

Thank you for your assistance in completing this form. Spokane Transit, in accordance with the American's with Disabilities Act of 1990, will use the information provided to determine the applicant's eligibility for Paratransit Services.

11/07

**Return application to:**

**Spokane Transit - Paratransit Services**

**1230 West Boone Avenue**

**Spokane, WA 99201-2686**

**Phone: (509) 325-6052**

**Fax: (509) 325-6030**