



Paratransit Service Application Form

Thank you for your interest in Spokane Transit Paratransit service!

All persons seeking eligibility for Paratransit service must complete the eligibility process that begins with completing this application form. For more information, see the Paratransit Eligibility brochure included with the application form or go to www.spokanetransit.com.

If you have any questions or need assistance completing this application form, we are happy to help you. Please call (509) 325-6052 or (509) 232-6303 for assistance.

INSTRUCTIONS

Before submitting the application form, please:

- Read the Paratransit Eligibility brochure included with the application form.
- Complete pages 1-5 of this application form. *Please print clearly.*
- Ensure the applicant or, if applicable, Legal Guardian or Power of Attorney (POA) signs the application form on page 4. **A signature is required before an application will be processed.**
 - If you have a legal guardian, the guardian is required to sign the application.
 - The parent or legal guardian of a minor is required to sign the application.
- Ensure page 6 is completed and signed by a medical/mental health provider. (See list of approved providers on page 5.)

ADDITIONAL ATTACHMENTS REQUIRED FOR A LEGAL GUARDIAN OR POA

- Provide copies of current Letters of Guardianship and the Order Appointing Guardian document from the court.
- Power of Attorney paperwork must include current documentation that grants the POA the right to sign a medical release form on behalf of the applicant.
 - Spokane Transit may require written documentation verifying the POA is in effect.

All 8 pages of the completed application form must be returned at the same time.

Your application for service is not complete until all required information is provided to STA and you have completed any required in-person assessments. There is no cost for the assessment and transportation will be provided if needed.



<input type="checkbox"/> New	<input type="checkbox"/> Recert
ID # _____	Exp: _____

PARATRANSIT SERVICE APPLICATION FORM

REVISED 1/2017

Last Name _____ First Name _____ M.I. _____

Mailing Address _____ Apt./Sp. # _____

City _____ State _____ Zip _____

The address where Paratransit will pick you up (if different from mailing address)

Street Address _____ Apt./Sp. # _____

City _____ State _____ Zip _____

Date of Birth _____ Male Female
MM/DD/YYYY

Home Phone (____) _____ Cell Phone (____) _____

Email Address _____

Emergency Contact _____ Relationship _____

Home Phone (____) _____ Cell Phone (____) _____

If we are unable to contact you, please list an alternative contact

Name _____ Relationship _____

Home Phone (____) _____ Cell Phone (____) _____

By providing emergency/alternate numbers, you authorize STA or its representatives to contact the individuals listed regarding your Paratransit service.

Do you speak and understand English? Yes No (specify other language below)

Applicant's Name _____

1. What is your disability or limiting condition? _____

2. Do your limitations change from time to time because of medical treatments, medications, or for other reasons? Yes No

If yes, please explain: _____

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

Long term Temporary - How long? _____

4. Is your memory affected due to your disability/limiting condition? Yes No

If yes: Short-term memory Long-term memory

5. Do you currently ride the regular bus? Yes No

Have you ever ridden the regular bus without someone's assistance?

Yes No If yes, how long ago? _____

6. Are you able to independently:

	Yes	No	Sometimes
travel to and from a bus stop?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
get on and off a ramp-equipped bus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ask for, understand, and/or follow directions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
plan, understand, and follow through with the actions necessary to take a bus trip?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you checked *no* or *sometimes* on question 6, please explain. (Use additional lines on Page 8, if necessary.) _____

Applicant's Name _____

7. Which of the following mobility aids or equipment do you use when you leave your home? Check all that apply and indicate the percentage of time you use the aid (example: support cane, 90%, no aids, 10%).

No aids	____%	Motorized wheelchair	____%
White cane	____%	Motorized scooter	____%
Support cane	____%	Manual wheelchair	____%
Crutches	____%	Other (please specify)	____%
Walker	____%	_____	

8. If you checked more than one aid, please describe the circumstances when you use each one. _____

If you use a scooter or wheelchair, skip to question 10.

9. When you **walk** outside your home, how far can you walk by yourself or with the use of a mobility aid such as a cane or walker?

Number of blocks _____ Less than 1 block Not able to walk any distance

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

Number of blocks _____ Less than 1 block Unable to self-propel

11. If you use a **power wheelchair or scooter**, how far are you able to travel without someone's assistance?

Number of blocks _____ Less than 1 block Not able to travel any distance

12. If you qualify for Paratransit service, will you need to:

	Yes	No	Sometimes
use the lift to board the van?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
bring a helper (Personal Care Attendant - PCA) with you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. Is there anything else about your disability/limiting condition that might help us better understand your travel abilities and limitations? (Use additional lines on Page 8, if necessary.) _____

Applicant's Name _____

DID YOU KNOW... Spokane Transit offers free training to learn how to ride the regular bus? *Participation in training is not a basis to limit or deny your Paratransit eligibility.*

Are you interested? Yes - An STA Mobility Trainer will contact you soon.

No (if no, please explain) _____

**Paratransit Service Applicant Agreement and
Authorization for Release of Information**

By signing this application, you authorize the release of verification information and any other information to Spokane Transit or its representatives needed to evaluate your eligibility to receive Paratransit service. Please be advised that Spokane Transit will use your statements to determine your eligibility for Paratransit service as provided by law. The statements contained herein are material to Spokane Transit's determination and Spokane Transit may act in reliance thereon.

Spokane Transit may share your eligibility determination with other transportation providers, on request, to facilitate travel in Spokane and other transit districts.

Documents used by Spokane Transit regarding your Paratransit eligibility, with the exception of information provided by your medical provider, may be subject to public disclosure in response to a public records request under Chapter 42.56 RCW. Spokane Transit will attempt to notify you should there be a public records request for your eligibility documents.

This form must be signed by the applicant or, if applicable, by the applicant's legal guardian or Power of Attorney (POA). If the applicant is under 18 years of age, a parent or legal guardian must sign this form. If the application is signed by a legal guardian or POA, attach current documentation supporting the right to sign.

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.

Signature (required)

Date

Applicant

Legal Guardian

Power of Attorney

Printed Name

Contact number

Applicant's Name _____

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

Name _____ Daytime Phone # _____

Relationship to Applicant _____ Agency _____

Please Note: A licensed Medical or Mental Health provider, who is familiar with you and your disability/limiting condition, must answer the questions on page 6 of this application form. Approved providers are limited to the following professions.

My approved provider is a (please check the appropriate box below):

- | | |
|---|---|
| <input type="checkbox"/> Medical Doctor (MD or DO) | <input type="checkbox"/> Licensed Mental Health Professional |
| <input type="checkbox"/> Optometrist or Ophthalmologist | <input type="checkbox"/> Physical or Occupational Therapist |
| <input type="checkbox"/> Psychologist (Ph.D.) | <input type="checkbox"/> MDS Nurse (From Skilled Nursing Facilities Only) |
| <input type="checkbox"/> Physician Assistant or ARNP | <input type="checkbox"/> Certified Orientation & Mobility Specialist |

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.

Please have your approved licensed provider complete page 6 of this Paratransit Application Form.



Applicant's Name _____

LICENSED PROVIDER VERIFICATION

Thank you for completing this application. Spokane Transit will use the information to help determine Paratransit eligibility in accordance with the Americans with Disabilities Act (ADA). Paratransit is a tax-supported service for individuals who, because of the effects of their disabilities/limiting conditions, are not able to ride the regular ramp-equipped and accessible STA bus. **Age, convenience of the service, fear of falling, inability to drive, and inability to carry packages are not qualifying factors for Paratransit service.** Please call (509) 325-6052 if you have any questions.

Please review the information provided by the applicant on this application form. Based on your knowledge of the applicant's condition, is the information accurate? Yes No Somewhat

If you checked *No* or *Somewhat*, please explain: _____

DIAGNOSIS/DISABILITY (not symptoms)	DEGREE OF IMPAIRMENT (circle one)			DATE OF ONSET (if known)
_____	mild	moderate	severe	_____
_____	mild	moderate	severe	_____
_____	mild	moderate	severe	_____
_____	mild	moderate	severe	_____
_____	mild	moderate	severe	_____

Is the applicant's need for Paratransit service temporary? Yes, until _____ No

If the applicant has a condition that is expected to improve, i.e. knee replacement or recent stroke, when do you expect the condition to stabilize? _____

Are any of these conditions episodic or variable in their severity? Yes - provide details below No

Provide any additional information that you deem relevant as to why the effects of the applicant's disability/limiting condition will prevent the applicant from using the regular bus service.

I HEREBY CERTIFY under penalty of perjury under the laws of the State of Washington that the information on the Provider Verification portion of this application form is true and correct.			
_____ Licensed Provider's Signature		_____ Specialty	_____ Date
_____ Printed Name	_____ Organization	_____ Phone	_____ Fax
_____ Address		_____ City	_____ State/Zip

APPLICANT

Thank you for providing the information STA needs to determine your eligibility for Paratransit. After Spokane Transit reviews your completed application form, you will be notified if additional information and/or an in-person assessment is required. STA will make the eligibility determination within 21 calendar days of receiving all the required information, and written notice will be sent to you.

If it takes longer than 21 days to finalize your eligibility, we will notify you that you qualify for temporary Paratransit service until the eligibility determination is made.

Please keep all 8 pages of this application together and return at the same time. Fold the form in half and return it to the address on the back page or FAX to (509) 325-6030.



**Paratransit Mobility Center
Spokane Transit – The Plaza
701 West Riverside Avenue
Spokane, WA 99201**

Spokane Transit assures nondiscrimination in accordance with Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act. For more information, visit www.spokanetransit.com. All phone numbers are accessible for people who are deaf or hard of hearing through Relay 711.

Upon request, alternative formats of this document will be produced for people who are disabled. Call (509) 325-6094 or email smillbank@spokanetransit.com.

ADDITIONAL INFORMATION

6. _____

13. _____

Other: _____

Please fold in half

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U.S.
Postage
Required