Call-A-Ride Paratransit Service
ADA Application Form

PLEASE READ CAREFULLY:

This application will be reviewed, and eligibility will initially be determined by Albany Transit System (ATS) in accordance with the eligibility criteria specified by the Americans with Disabilities Act of 1990 and adopted by the City of Albany. See attached eligibility information.

It is extremely important that the form is filled out ***completely***. Any incomplete applications will be returned without being processed. Staff may consult with appropriate professional experts regarding your eligibility at any stage of the certification process if it is deemed necessary. Submission of this application does not guarantee eligibility.

ATS determination will be in writing (or other acceptable format if requested) and will inform the applicant of the approval or denial of eligibility. In the case of a denial, the reason(s) will be noted. If eligibility is made conditional or denied, a full description of the appeals process shall be included with the written determination.

Upon completion of this application, please return it to:

Albany Transit System
Attn: Paratransit Services Supervisor
PO Box 490
Albany, OR 97321
FAX: 541- 791-0131
ted.frazier@albanyoregon.gov
kim.daniels@albanyoregon.gov

If you do not meet the criteria described in the attached material, please contact the Albany Transit System information service for information on the fixed route system. If you would like a copy of the eligibility criteria as defined in the Federal Register or have any questions regarding eligibility, please contact the Albany Transit System at 917-7667.

FOR OFFICE USE ONLY

☐Accepted ☐Denied

Date: ____________________

By: ____________________

☐Permanent ☐Temporary

Expiration Date:

____

PART 1. GENERAL INFORMATION

Type or print clearly. Application must be complete in order to process.

Last Name: ____________ First Name: ____________ MI: ______

Street Address: ____________ Apt/Bldg#: ______

City: ____________ State: ____________ Zip: ______

Nearest cross street or directions to your residence: ____________

Phone-Home: ____________ Phone-Other: ____________

Date of Birth: ____________

Mailing Address *(if different from above)*:

Street Address: ____________ Apt/Bldg#: ______

City: ____________ State: ____________ Zip: ______

Are you currently on Medicaid?:

☐Yes

☐No

Albany Call-a-Ride is a Medicaid Non-Medical transportation provider. Contact your Medicaid benefits coordinator to find out if you qualify.

Do you need to have information and material given to you in any of the following ways?:

☐Large Print

☐Audio Tape

☐Braille

☐Other______________________

EMERGENCY CONTACT:

Name: ____________ Relationship: ____________

Phone-Home: ____________ Phone-Work: ____________

Phone-Other: ____________

If someone assisted you in completing this form, please identify them below:

Name: ____________ Relationship: ____________

Phone-Home: ____________ Phone-Work: ____________

Representative's signature: ____________

PART 2. INFORMATION ABOUT THE APPLICANT'S DISABILITY

To be completed by Applicant or Representative.

1) Please indicate below your ability to use Albany Transit Service (ATS) buses:
Check all that apply.
☐I can use city buses to go some places, but in other places I cannot get to or from the bus stops.
☐I can use city buses sometimes, but only if they are equipped with wheelchair-lifts.
☐Because of my disability, I can never use the city bus service.

2) What type or types of disabilities prevent you from using the Albany Transit System (ATS)?:
Check all that apply.
☐physical disability
☐visual impairment/blindness
☐developmental disability
☐mental illness
☐other ______________________
☐none

Please describe your disabilities in more detail:

____

____

3) Is your disability temporary or permanent?
☐Temporary, I expect it to last for another ________ months
☐Permanent
☐I don't know

4) Please indicate below if you use any of the following mobility aids or equipment.
☐I don't use any mobility aids or equipment
☐cane
☐long white cane
☐leg braces
☐crutches
☐walker
☐picture board
☐alphabet board
☐hearing aid
☐low vision aid
☐oxygen tank
☐manual wheelchair
☐powered wheelchair
☐powered scooter/cart
☐other
____
☐service animal (describe)
____

Note: Call-A-Ride may not be able to accommodate you if your wheelchair/scooter is longer than 48" or wider than 30" when measured 2 inches from the ground, or if the total combined weight of you and your wheelchair is more than 600 pounds.

5) Persons with dementia or Alzheimer's disease cannot be left alone. Does someone <u>ALWAYS</u> need to meet you when you arrive at a destination?
☐Yes, **there *must* be someone to meet you on all trips**. If no one meets you at your destination, Call-A-Ride will contact the person listed under the emergency contact section of the application.
☐No

6) Using a mobility aid or on your own, how far can you travel?

On my own:

☐I cannot travel outside my house/apartment
☐I can get to the curb in front of my house/apartment
☐I can travel up to 3 blocks (1/4 of a mile)
☐I can travel up to 6 blocks (1/2 of a mile)
☐I can travel up to 9 blocks (3/4 of a mile)
☐I have no limitations on how far I can travel

With my mobility aid:

☐I cannot travel outside my house/apartment
☐I can get to the curb in front of my house/apartment
☐I can travel up to 3 blocks (1/4 of a mile)
☐I can travel up to 6 blocks (1/2 of a mile)
☐I can travel up to 9 blocks (3/4 of a mile)
☐I have no limitations on how far I can travel

7) Do you require the assistance of a Personal Care Attendant or someone who assists you with daily life functions?

☐No
☐Yes, I need assistance when I travel with (check all that apply):

☐mobility ☐eating ☐medication
☐communicating ☐transfers ☐other _______________

Note: Drivers will not be able to perform the duties of a Personal Care Attendant. If you need the services of a PCA you must provide one.

PART 3. QUESTIONS ABOUT USING CITY BUSES

1) Have you ever used the Albany Transit System (ATS)?

☐Yes, I typically use the city buses (ATS) _______________ times a week
☐Yes, I used to but stopped because ____
☐No, I have never used the city bus (ATS)

2) Is there something that might help you ride ATS buses (check all that apply)?

☐Yes, route and schedule information
☐Yes, learning to use the buses
☐Yes, being able to get buses with lifts
☐Yes, a communication aid
☐Yes, if bus stops were closer to where I live and where I need to go
☐Other ________________________
☐No, none of these would help

3) Can you ask for and follow written or oral instructions to use the city buses?

☐Yes ☐Sometimes ☐No

If you answered No or Sometimes, please check all that apply:

☐I get confused and may get lost
☐I cannot read
☐I cannot communicate with other people
☐I probably could with instruction
☐Other ________________________

4) Are you able to get to and from bus stops on your own?

☐Yes ☐Sometimes ☐No / Never Tried

If you answered No or Sometimes, please check all that apply:

☐I can't get places if there are no curb-cuts
☐I don't know, I have never tried
☐I can't if the street or sidewalk is too steep
☐I cannot cross busy streets and intersections
☐I cannot travel outside when it is too hot/cold
☐I can't find my way at night because of a vision problem
☐I get confused and cannot find my way
☐I feel unsafe traveling alone
☐I probably could with instruction
☐Other ________________________

5) Can you wait up to 30 minutes for a city bus at a bus stop?

☐Yes
☐Yes, but only if the stop has a bench and shelter
☐Yes, but I don't like to wait that long
☐No (explain):____________________________________

6) Can you get on and off a city bus?

☐Yes
☐No
☐Sometimes
☐I don’t know, I have never tried

If No or Sometimes, please check all that apply:
☐Only if the bus has a wheelchair lift
☐I cannot climb the stairs
☐I don't want to use the lift
☐I probably could with instruction
☐Other___________________________________

Note: all city buses now have lifts and a "kneeler" which lowers the height of the steps. Passengers who find the steps to be too high may enter and exit the bus by standing on the lift.

7) If you are able to get on and off city buses, can you get to a seat or wheelchair position by yourself?

☐Yes
☐No
☐Sometimes
☐I don’t know

If No or Sometimes, please check all that apply:
☐I need someone to help me
☐I have a balance problem
☐I have trouble finding seat
☐I need the seat nearest the door
☐Other___________________________________

8) If you are able to get on and off city buses, do you know where to get off the bus or can you find out by yourself?

☐Yes
☐No
☐Sometimes
☐I don’t know

If No or Sometimes, please check all that apply:
☐I get confused or can't remember where I am going
☐I can if the driver calls out the stops
☐I probably could with training
☐Other___________________________________

9) Are there any other conditions that limit your ability to use the city buses?

☐Yes *(Please describe them below)*
☐No

____

____

PART 4. INFORMATION ABOUT TRAVEL TRAINING

1) Have you ever had any personal instruction on how to use city buses?
☐Yes, I have received personal instruction from a friend/relative
☐Yes, I have received personal instruction through an agency *(Name of agency: ____________________)*
☐No, I have not received any personal instruction

Indicate below all of the skills you learned:
☐to travel to and from bus stops
☐to cross streets
☐reading bus schedules and planning trips
☐to ride the following routes (please list them):
Route #________Route #_________Route #_________Route #_________Route #_________
☐Other____

2) Did you complete the instruction described above?
☐Yes
☐No

3) ATS now offers free instruction to anyone interested in learning how to ride the city buses. Would you be interested in getting information about this service?
☐Yes
☐No

PART 5. APPLICATION SIGNATURE

I understand that the purpose of this evaluation form is to determine if there are times when I cannot use the city bus service provided by Albany Transit System and must therefore use Call-A-Ride paratransit service for transportation assistance. I understand that the information about my disability contained in this application will be kept confidential and shared only with professionals involved in evaluating my eligibility. I certify that, to the best of my knowledge, the information in this evaluation form is true and correct. I understand that providing false or misleading information could result in my eligibility status being re-examined as well as other actions by Albany Transit Service.

Applicant's Signature:____ Date:__________________

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PART 6. HEALTH CARE RELEASE FOR INFORMATION

Last Name: ______________________ First Name: ______________________ MI: ______

Please contact the following *(Please choose one)*:
☐Physician
☐Health Care Professional
☐Rehabilitation Professional

HEALTH CARE INFORMATION

Professional's Name: ____

Office Phone: ______________________ Office Fax: ______________________

Mailing Address: ____

City: ______________________ State: ______________________ Zip: ______

Today's Date: ________________

Dear ______________________________,
(Medical Professional)

I have asked Albany Transit System to determine my eligibility for ADA complimentary paratransit service.
You are hereby authorized to disclose any information about me that may be helpful for Albany Transit to make that determination.

HIPAA Statement: I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care treatment from you, however it may impact the ability of Albany Transit System to determine my eligibility for paratransit services. I understand that I may cancel this authorization in writing at any time. The cancellation will not affect any information that you disclose prior to cancellation. This authorization will expire one year form the date of this letter. I understand that the information released may be subject to re-disclosure and no longer protected under federal and state law.

___________________________________ ___________________________________
Signature of applicant or Legal Representative Relationship to applicant *(if applicable)*

If I wish to revoke this authorization, I will send a written request with a copy of this form to you at the address above.

____
Initials

HEALTH CARE PROFESSIONAL QUESTIONNAIRE

Health Care Professional, please complete the following:

1) Capacity in which you know this applicant:

____

2) Can the applicant travel 200 feet without assistance?

☐Yes ☐No ☐Sometimes

3) Can the applicant travel 1/4 mile (5 city blocks) without assistance?

☐Yes ☐No ☐Sometimes

4) Can the applicant climb three 12-inch steps without assistance?

☐Yes ☐No ☐Sometimes

5) Can the applicant wait outside without support for 15 minutes?

☐Yes ☐No ☐Sometimes

6) Does the applicant have vision problems that would prevent him/her from using city transit buses?

☐Yes ☐No ☐Sometimes

7) Is the applicant able to state addresses and telephone numbers on request?

☐Yes ☐No ☐Sometimes

8) Is the applicant able to recognize destinations and landmarks?

☐Yes ☐No ☐Sometimes

9) Is the applicant able to deal with unexpected situations or unexpected changes in routines?

☐Yes ☐No ☐Sometimes

10) Is there any additional information of which Albany Transit should consider when determining ADA paratransit eligibility for the applicant?

____

____

_____________________________________ _____________________________________

Signature of Health Care Professional | Print Name of Health Care Professional

Date: ______________ Phone Number: ______________________

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