Call-A-Ride Application

What is Paratransit?

Paratransit is an alternative, origin-to-destination, demand-response service. It is designed to "complement" the fixed route bus service in terms of times and areas. Paratransit service is not required, nor intended, to meet all the transportation needs of persons with disabilities. Rather it is intended to provide public transportation in a more specialized form.

Origin-to-destination provisions of ADA mean that assistance is provided to individuals between the door of their starting point or destination and the paratransit vehicle. In addition, paratransit is only required to provide service if both the starting and destination points are within ¾ of a mile of a fixed route bus route during the hours when that route is in operation.

Disability alone does not determine paratransit eligibility; the decision is based on the applicant's functional ability to use the fixed route bus and is not a medical decision. Age, inability to drive, utilizing a mobility device, income or not having access to a car are NOT eligible disabilities for purposes of determining ability to use fixed route.

Who qualifies for paratransit?

Under the Americans with Disability Act (ADA), disability alone does not qualify a person to ride paratransit. Paratransit service is designed to serve those persons whose severity of disability prevents them from using public transportation. A person must be FUNCTIONALLY unable to use the fixed route bus service. Service is provided to the following three general groups of persons with disabilities:

1. Persons who have specific impairment-related conditions which make it IMPOSSIBLE -not just difficult- to travel to or from a bus route location point.
2. Persons who need a wheelchair lift and a wheelchair lift-equipped bus is not available on the route when they need to travel.
3. Persons who are unable to board, ride, or exit from a fixed route bus even if they are able to get to a location point on the route and the bus is equipped with a wheelchair lift

Race and Ethnic Data

THE FOLLOWING IS FOR STATISTICAL PURPOSES ONLY AND IS VOLUNTARY

____ Applicant declined to answer the above questions

PLEASE MARK ONE ON EACH SECTION

- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ White
- ☐ Asian and White
- ☐ American Indian or Alaska Native and Black or African American
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ American Indian or Alaska Native and White
- ☐ Black or African American and White
- ☐ Other multiple race Combinations greater than one percent

- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino

Signature: _____ Date_____

!!!ATTENTION!!!

Any question not answered in this application will result in a denial

GENERAL INFORMATION (Please print) the information on this form will be used solely for the purpose of determining eligibility for Call-A-Ride paratransit service. The information that you provide will be kept strictly confidential.

First Name _____Middle Initial_____

Last Name _____

Street Address _____Apt. Number_____

Mailing Address (if different) _____

City _____ State_____ Zip Code_____

Date of Birth (month / day / year) _____Sex (M/F) _____

Daytime phone _____ Work phone _____

Name and phone number of a friend or relative we can contact in case of an emergency or unable to reach you at your regular number:

Name _____

Relationship _____ Phone Number _____

1. Do you have a disability, which prevents you from using the Basin Transit Association fixed route bus services? _____ **Yes** _____ **No**

If yes, please describe any and all physical, mental, visual or functional disabilities, **which prevent** you from using the Basin Transit Association (BTA) fixed route bus services.

_____
_____
_____
_____

If no, please explain why you feel you are eligible for Call-A-Ride.

_____
_____
_____
_____

2. Is your disability a permanent condition? _____**Yes** _____ **No**

If no, how long do you expect to have this disability? _____ (Date)

3. Do you use any of the following mobility aids? ***(Please check all that apply)***

- □ **Motorized wheelchair** □ **Manual wheelchair** □ **Powered scooter**
- □ **Personal care attendant** □ **Walker** □ **Cane**
- □ **Crutches** □ **Service animal** □ **Prosthesis**

Other: _____

NOTE:

BTA will not transport a mobility aid that exceeds the "common wheelchair" parameters as set forth in the ADA regulation manual (49 C.F.R. Section 37.3), including mobility aid that:

(1) Is longer than 48 inches, measured 2 inches above the ground

(2) Is wider than 30 inches

(3) Weighs more than 600 pounds when occupied

4. Do you travel with someone that assists you?

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

5. Using mobility aid or on your own, how far are you able to travel without the assistance of another person? (Check all that apply)

__ ½ block __ 1 block __ 2 blocks

__ 4 blocks __ more than 4 blocks

__ climb three 12-inch steps __ wait outside without support for ten minutes

6. How far is the closest bus stop to where you live?

___ within a block ___1/4 mile ___1/2 mile ___3/4 mile ___ unsure

7. Do you currently ride a BTA fixed route bus independently?

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

8. If you do not presently use BTA fixed route services, what are the conditions of your disability, which prevent you from riding the bus?

_____
_____
_____

9. Does weather impact your ability to travel? ____Yes ____ No

If yes, please explain how weather condition(s) impact your ability to ride the fixed route bus.

_____
_____
_____
_____
_____

10. List your most frequent destinations and how you get there currently.

_____
_____
_____

11. Can you cross the street? _____Yes _____ No _____ Sometimes

What best describes your ability to use the BTA fixed route buses?

- ☐ **I can get to and from bus stops if the distance is not too great.**
- ☐ **The severity of my disability or health condition can change from day to day. I can ride the fixed route buses when I am feeling well, but not at other times.**
- ☐ **I have a disability or health condition which prevents me from riding the fixed route buses if the weather is too hot or too cold.**
- ☐ **My disability or health condition makes it difficult or impossible to travel when there is snow and ice.**
- ☐ **I cannot climb stairs to get on and off the fixed route buses.**
- ☐ **I can get to and from bus stops only if there are curb-cuts and level sidewalks.**
- ☐ **I have difficulty understanding or remembering all the things I would have to do to use the fixed route buses.**
- ☐ **I can use the fixed route buses if it's someplace I go all the time.**
- ☐ **I can never use the fixed route buses by myself.**
- ☐ **I would like training information on how to use the BTA fixed route buses.**
- ☐ **I am not able to use the fixed route buses for other reasons. Please explain:**

_____
_____
_____
_____
_____

☐ I hereby affirm that the statements made herein are true and correct and I understand that falsification of information may result in denial of service.

☐ I authorize the listed health care professional to release information about my disability and its affect on my ability to travel, which may be needed in connection with my request for Call-A-Ride eligibility certification. It is my understanding that the information released will be used solely to determine my ADA paratransit eligibility. I understand that I may revoke this authorization at any time. Unless earlier revoked, this form will permit the professional listed to release the information described until 60 days after the date appearing below.

☐ I authorize Basin Transit Association to have access to my disability information in order to assist me in my travel needs.

Applicant's Signature: _____Date: _____

Applicant's Name: _____
(PLEASE PRINT)

If someone other than the applicant completed this form on behalf of the applicant, that person must complete the following:

Name: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Signature: _____ Date: _____

Relationship to Applicant: _____

Send completed application to:

Uintah Basin Association of Governments
Basin Transit Association

330 East 100 South
Roosevelt, UT 84066
(435) 722-4518 Phone
(435) 722-4890 Fax

Professional Certification Instructions

Dear Doctor:

The applicant who has asked you to complete and sign this form is applying for eligibility on the BTA Paratransit service. Please read the following information carefully since it may affect your response.

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Origin-to-destination provisions of ADA mean that assistance is provided to individuals from curb-to-curb. In addition, paratransit is only required to provide service if both the starting and destination points are within ¾ of a mile of a fixed route bus route during the hours when that route is in operation.

(Age, inability to drive, utilizing a mobility device, income or not having access to a car are NOT eligible disabilities for purposes of determining ability to use fixed route)

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4. Persons who have specific impairment-related conditions which make it IMPOSSIBLE -not just difficult- to travel to or from a bus route location point.

5. Persons who need a wheelchair lift and a wheelchair lift-equipped bus is not available on the route when they need to travel.

6. Persons who are unable to board, ride, or exit from a fixed route bus even if they are able to get to a location point on the route and the bus is equipped with a wheelchair lift.

(Please complete the appropriate form)

Questions to be completed for the ***Physically Handicapped*** Person by a Medical Doctor.

(PRINT CLEARLY)

Name of Applicant: _____

Medical Diagnosis of handicapping condition: _____
_____
_____

- Is this condition temporary? ___Yes ___ No
    - If yes, Expected duration until: _____
- Is this condition likely to become worse? ___ Yes ___ No
- Is this person able to walk without the assistance of another person:
  a) 200 feet? ___ Yes ___ No ___ Only with great difficulty.
  b) ¼ mile? ___ Yes ___ No ___ Only with great difficulty.
- Is this person able to climb a 16" step and two 10" steps? ___ Yes ___ No ___ Only with great difficulty.
- Is this person able to wait outside without support for 10 minutes? ___All of the time ___ Some of the time ___ Not at all
- Is this person able to ride in an automobile (including getting in and out?) ___ All of the time; ___ Some of the time; ___ Not at all
- Does this person require the use of the following:

__ Wheelchair	__ Service Animal	__ White Cane
__ Crutches	__ Walker	__ Electric Scooter
__ Braces	__ Personal Care Attend.	__ Cane
__ Other (describe):_____		

Is there any other effect of the condition of which BTA should be aware? (Please describe):
_____
_____
_____
_____

CERTIFICATION Please review the medical information provided in the application and fill out the certification as is appropriate and sign the document. The information you provide will help us to serve those who most need paratransit.

I, _____ certify _____ (Print Name of Physician) (Print Name of Patient) to be a disabled person and that the medical information provided in the application is accurate to the best of my knowledge and is consistent with the applicant's medical diagnosis. Signed this _____ day of _____, 20__

Signature of Physician: _____

Print Name of Physician: _____

License Number:_____

Address: _____

Telephone No.: _____

BTA Basin TRANSIT ASSOCIATION

Uintah BASIN ASSOCIATION OF GOVERNMENTS

Questions to be completed for the ***Visually Handicapped*** person by a medical doctor, ophthalmologist, or optometrist.

(Print clearly)

Name of Applicant: _____

Medical diagnosis of handicapping condition: _____
_____
_____
_____

Is this condition temporary? ___ Yes ___ No If yes, Expected duration until: _____

Is this condition likely to become worse? ___ Yes ___ No

Visual Acuity: Right Eye: ____/____ Left Eye: ____/____

Visual Field: Right Eye: Horizontal_____ Left Eye: Horizontal_____
Vertical _____ Vertical _____

Is there any other effect of the condition of which BTA should be aware? Please describe:
_____
_____
_____

CERTIFICATION Please review the medical information provided in the application and fill out the certification as is appropriate and sign the document. The information you provide will help us to serve those who most need paratransit.

I, _____ certify _____ (Print Name of Professional) (Print Name of Patient) to be a disabled person and that the medical information provided in the application is accurate to the best of my knowledge and is consistent with the applicant's medical diagnosis. Signed this _____ day of _____, 20__

Signature of Professional: _____

License Number: _____

Address: _____

_____

Telephone No.: _____

Questions to be completed for the ***Mentally Handicapped*** person by a qualified medical Doctor or Psychiatrist

(print clearly)

Name of Applicant: _____

Medical diagnosis of handicapping condition: _____
_____
_____

How does this condition affect the individual's ability to use fixed-route bus service?
_____
_____

Is this person able to:

a) Give address and telephone number on request ___ Yes ___ No
b) Recognize streets and bus numbers ___ Yes ___ No
c) Sign his/her name ___ Yes ___ No
d) Deal with an unexpected situation ___ Yes ___ No
e) Ask for and understand directions ___ Yes ___ No

Is this condition:

a) Temporary? ___Yes ___No
If yes, expected duration_____
b) subject to significant improvement with treatment? ___ Yes ___ No
c) likely to become worse? ___ Yes ___ No

Should this person be accompanied while using BTA Paratransit Service? ___ Yes ___ No

Is there any other effect of the condition of which BTA should be aware? Please describe:
_____
_____

CERTIFICATION Please review the medical information provided in the application and fill out the certification as is appropriate and sign the document. The information you provide will help us to serve those who most need paratransit.

I, _____ certify _____ (Print Name of Professional) (Print Name of Patient) to be a disabled person and that the medical information provided in the application is accurate to the best of my knowledge and is consistent with the applicant's medical diagnosis. Signed this _____ day of _____, 20__

Signature of Professional: _____
License Number: _____
Address: _____
Telephone No.: _____

UINTAH BASIN TRANSIT ASSOCIATION

RELEASE OF MEDICAL INFORMATION AND DISABILITY VERIFICATION

Patient Section (Applicant): Please Print

I _____, authorize my medical provider, _____, to release to Uintah Basin Transit Association Program any information regarding my current physical condition as it relates to disability status.

_____ _____

Signature of Patient or Designee Date

Needed from applicant:

Fully completed application

Needed from Physician:

Appropriate disability form filled out and sent to BTA within 5 days with medical release form

Things that will cause a delay/prevent BTA from processing an application:

- **ANY material questions related to your disability that are left unanswered**
- **Missing signatures on application or physicians section**
- **If physicians section is completed by anyone other than a licensed professional**
- **If the licensed or certified professional completing that section does not include their full name, title, address and license or certification number**
- **If applicant does not call to schedule or follow through with the in-person interview/assessment (these assessments will be starting within the next year, you will be notified by mail when your first one will take place)**

CONFIDENTIALITY STATEMENT: Confidentiality agreements are in place and laws regarding the confidentiality and transport of medical information are enforced.

The correct doctor's form and medical release must be faxed to the Basin Transit Association Program by the doctor's office to be valid. Please return within 5 business days.

Basin Transit Association Program: Fax 435-722-4890 Attention: _____