Application For ADA Paratransit Service

STSF01

Application ID:

THANK YOU FOR APPLYING FOR CHARLOTTE AREA TRANSIT SYSTEM (CATS) SPECIAL TRANSPORTATION SERVICE (STS)

STS is the paratransit service CATS provides to individuals who are unable to use fixed-route bus service because of a disability. STS provided van/shared ride services to persons determined to be "ADA paratransit eligible." STS is meant to assist individuals who cannot independently take a bus because of a physical, visual, or cognitive disability.

TYPES OF ELIGIBILITY

UNCONDITIONAL: You can use STS due to an inability to ever use the fixed-route bus independently
CONDITIONAL: You can use STS when your specific "condition" prevents you from using the fixed-route bus
TEMPORARY: You can use STS for a temporary timeframe while your ability to use the bus is expected to improve or change
INELIGIBLE: You have been determined to have the abilities to use a fixed-route bus independently and therefore are not eligible to use STS paratransit. The appeals process is available, and instructions are provided in the ineligible letter.

HELP

IF YOU NEED ASSISTANCE COMPLETING THE APPLICATION, PLEASE CONTACT ADARIDE @ (877) 232-7433.
Please forward both completed forms to:
ADARIDE 19300 S. HAMILTON AVE SUITE #120 GARDENA, CA 90248
or FAX to: (310) 410-0239 or
Email to: info@adaride.com

PROCESSING TIMES

Once you completed application is received, we will begin your determination for STs paratransit service. If the application and verification alone does not establish STS paratransit eligibility, or is unclear / contradictory / ambiguous, you will be contacted immediately for an in-person Mobility Conference. If you are unable to get transportation to attend the in-person Mobility Conference , STS will provide a ride to and from the location at No COST to you. Once you complete the entire application process, including a possible In-person Mobility Conference, we have 21 days upon which to make a determination and notify you in writing.
Application ID:

Personal data

First name: _____ Middle name: _____

Last name: _____ Sex: _____

Default language: _____ TDD: _____

Date of birth: _____ Place of birth: _____

E-mail address: _____ Format: _____

Username: _____

Day phone: _____ Evening phone: _____

Mobile: _____

Mailing address

Street#: _____ Street_____ Apt#: _____
City: _____ State: _____ Zip code: _____ _____

Home address

Street#: _____ Street: _____ Apt#: _____
City: _____ State: _____ Zip code: _____
Application ID:

Personal Care Attendant

1. Do you require a Personal Care Attendant? ☐ Yes ☐ No

Checking yes on Personal Care Attendant (PCA) means you need someone to travel with you in order to successfully complete a trip. A PCA is not provided to you, it is your responsibility to bring one and they travel for free.

Did someone help fill out this application?

2. Did someone help you fill out this application? ☐ Yes ☐ No

First name: _____ Last name: _____

E-mail address: _____ Phone: _____

Relationship: _____ Contact this person: ☐ Yes ☐ No

Emergency contact

3. Do you wish to provide your emergency contact information? ☐ Yes ☐ No

First name: _____ Middle Name: _____

Last name: _____ E-mail address: _____

Day phone: _____ Evening Phone: _____

Mobil phone: _____ Relationship: _____

Street#: _____ Street: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Application

Applicant's medical conditions

4. What is your medical conditions(s) / Disability? _____

_____

5. Is this a temporary disability or health condition?

☐ Yes ☐ No

6. Are you currently receiving any treatment?

☐ Yes ☐ No

7. If yes, how long will you be receiving treatment?

☐ 1 – 3 months ☐ 3 – 6 Months ☐ 6 – 9 months

☐ 9 – 12 months ☐ Over a year

8. What treatment are you receiving?

☐ None ☐ Physical Therapy ☐ Chemotherapy

☐ Radiation Therapy ☐ Dialysis ☐ Psychotherapy

☐ Non-Weight Bearing Immobilization ☐ Weight-Bearing Immobilization ☐ Travel Training

☐ Rehabilitation Program ☐ Surgery ☐ New medications

☐ Medications ☐ Convalescence ☐ Other

9. Please Read the following statements and check the one that best describes your disability

☐ I am able to ride the transit system independently

☐ I believe I can learn to ride the city bus is someone taught me how to ride.

☐ I can use the city bus for certain trips but not others.

☐ I have a temporary disability and will only need CATS until I recover.

☐ I am not able to ride the city bus by Myself

Application ID:

10. Do you currently use a mobility device when going places? ☐ Yes ☐ No

11. If yes, check applicable in the list.

☐ Power/Electric Wheelchair
☐ Manual Wheelchair
☐ Scooter
☐ Sport Wheelchair
☐ Walker
☐ Service Animal
☐ Prosthesis
☐ Cane
☐ White Cane
☐ Crutches
☐ Portable Oxygen
☐ None
☐ Other
☐ Communication Board
☐ Leg Braces
☐ Picture/Alphabet Board
☐ Segway

12. Is you scooter/wheelchair wider than 30”?

☐ Yes ☐ No ☐ I don’t know ☐ N/A

13.Is you scooter/wheelchair longer than 48”?

☐ Yes ☐ No ☐ I don’t know ☐ N/A

14. Is the total combined weight of you and your mobility device more than 600 lbs?

☐ Yes ☐ No ☐ I don’t know ☐ N/A

15. Description:

_____

16. Do you use the bus INDEPENDENTLY?

☐ Yes / Sometimes ☐ No / Don’t Know ☐ Possibly, with training

Fixed Routes

17. If you use the city bus independently, specify your routes:

_____

First Route

Destination Name: _____

Routes: _____

Street#: _____ Street: _____

City: _____

☐ With transfer?

Second route

Destination Name: _____

Routes: _____

Street#: _____ Street: _____

City: _____

☐ With transfer?

18. Would you require someone to travel with you when riding an accessible bus (Personal Care Attendant)?

☐ Yes ☐ No ☐ Sometimes

☐ Don't know

If you have chosen yes, please explain:

_____

19. CATS offers travel training to those who want to learn how to use a bus. By answering yes to this question, CATS may contact you to schedule an appointment . Are you interested in travel training?

☐ Yes ☐ No

20. do you have a hearing problem that would prevent you from using a bus?

☐ Yes ☐ No

If you have chosen yes, please explain:

_____

21. Do you have a visual problem that would prevent you from using the bus?

☐ Yes ☐ No

If you have chosen yes, please explain:

_____

22. Do you have a memory problem that would prevent you from using the bus?

☐ Yes ☐ No

If you have chosen yes, please explain:

_____

23. Do you have a balance problem that would prevent you from using the bus?

☐ Yes ☐ No

If you have chosen yes, please explain:

_____

24. Do you have a breathing problem that would prevent you from using the bus?

☐ Yes ☐ No

If you have chosen yes, please explain:

_____

25. Would you have problems standing at a bus stop for 15 minutes if there is no place to sit?

☐ Yes ☐ No

If you have chosen yes, please explain:

_____

26. Would you have problems counting money and paying the bus driver?

☐ Yes ☐ No

If you have chosen yes, please explain:

_____

27. Would you have a problem independently crossing a street?

☐ Yes ☐ No

If you have chosen yes, please explain:

_____

28. How far can you walk (using mobility device is applicable) or wheel without resting?

29. Do any of the following prevent you from using the bus?

☐ Cold
☐ Heat
☐ Rain
☐ Night Blindness
☐ Snow
☐ Light sensitivity(sunny, overcast, etc.)
☐ Lack of sidewalks
☐ Lack of curb cuts
☐ Uneven travel path (dirt road, pot holes, ect.)
☐ Hill
☐ Bus stop not accessible
☐ unable to walk/wheel 50 feet (1 block)
☐ Air pollution (smog, allergies)
☐ Good/Bad Day
☐ Unable to walk/wheel 1/4 mile (3 blocks)
☐ Lack of strength and endurance (hyper fatigue)
☐ Unable to transfer buses
☐ Unable to walk/wheel 3/4 mile (9 blocks)
☐ None

By signing this term, I understand I am giving consent for ADAride.com and Charlotte Area Transit (CATS) to use and disclose my protected health information for the following purposes and activities.

1) To transfer information to transportation providers and mobility services
2) Permission to contact your healthcare provider to verify your disability and treatment plan for purposes of paratransit eligibility.
3) The information provided is true and correct to the best of my knowledge.
4) I agree to inform CATs when there are significant changes in my mobility.

ADAride.com and CATS appreciate your cooperation in this process and assure you that your protected health information will be managed through strict HIPAA (Health Insurance Portability and Accountability Act) Compliant policies and procedures.

I realize that I have the right to review and receive a copy of this consent form before signing. I hereby certify that the information provided during the eligibility process is true and correct to the best of my knowledge. I understand that misrepresentation in this process or presented during my assessment may result in denial of privileges to use paratransit services.

Signature: _____ Date: _____

Do you have any notes or restrictions on your release?

_____

HEALTHCARE PROFESSIONAL VERIFICATION

(FOR PROFESSIONAL USE ONLY)

YOUR CLIENT / PATIENT IS APPLYING FOR CATS STS PARATRANSIT SERVICE

The information shared will be protected per the requirements identified in the Heath insurance Portability and Accountability Ave(HIPPA) and you patient / client has agreed to allow Charlotte Area Transit System and its eligibility contractor, ADAride.com to contact you for this information via the application. Your cooperation and assistance is greatly appreciated. If you have any questions or comments, please do not hesitate to contact us @ 1-877-232-7433, www.adaride.com, and fax @ 310-410-0239.

SEND THIS FORM SECURLEY TO:

Please forward both COMPLETED forms to:
ADARIDE 19300 S. HAMILTON AVE SUITE #120 GARDENA, CA 90248
or FAX to: (310) 410-0239
or Email to: info@adaride.com

HEALTHCARE PROFESSIONALS QUALIFIED TO COMPLETE THIS FORM

Rehab Specialist
Independent living counselor
Social Worker / Family Counselor
Psychologist / Psychiatrist
Occupational / Physical Therapist / Assistants
Medical Doctor / DO
Registered Nurse / Nursing Assistant / Medical Assistant
Special Education Teacher

CLIENT / PATIENT FIRST AND LAST NAME:

_____

_____

Your professional information

First name: _____ Middle name: _____

Last name: _____ Professional License #: _____

Profession: _____ E-mail address: _____

Day phone: _____ Mobile phone: ___-___-_____

Address

Street#: _____ Street: _____ Apt#: _____

City: _____ State: _____

1. Please list the diagnosis you are treating you client / patient for and any other diagnosis that your client may have

_____

_____

2. Please indicate which of the following category most limits you client / patient.
You can check more than one category if both disabilities limit your client's / patient's independence and mobility.

☐ Mental ☐ Physical ☐ Visual

If you have chosen Physical, please choose categories:

☐ Cardiovascular
☐ Gastrointestinal disorders
☐ Geriatric disorders
☐ Infectious diseases / immunology
☐ Neurological disorders
☐ Oncology and hematology
☐ Organ failure / transplant / diabetes
☐ Orthopedic conditions
☐ Other
☐ Pediatric disorders
☐ Pulmonary disorders

3. Which statement best describes you patient's condition?

- ☐ Being treated and hopes to improve
- ☐ Permanent condition that is not Expected to change
- ☐ Disease is advanced and considered terminal
- ☐ Condition should not interfere with Independent bus usage
- ☐ None of the above

4. Prognosis:

_____

5. Treatment plan with start date and anticipated completion date:

_____

6. Have you ever prescribed or are aware of a device your client / patient currently uses?

- ☐ None
- ☐ Cane
- ☐ Power Wheelchair
- ☐ Crutches
- ☐ Manuel Wheelchair
- ☐ Scooter
- ☐ White Cane
- ☐ Walker
- ☐ Leg Braces
- ☐ Portable Oxygen
- ☐ Service Animal
- ☐ Prosthesis
- ☐ Folding Walker

7. Are you aware of any challenges you client / patient has with balance?

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Do not know

If you have chosen Yes/sometimes, please elaborate:

_____

8. Are you aware of any challenges your client / patient has with strength and endurance?

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Do not know

If you have chosen Yes /sometimes , please elaborate:

_____

9. Do you think your patient/client could independently ambulate / wheel 3/4 of a mile (about 9 blocks with a mobility device and brief rest periods if needed)?

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

_____

10. Are you aware of any challenges your client / patient has with memory?

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

_____

11. Are you aware of any challenges your client / patient has with crossing streets?

☐ Yes ☐ No ☐ Sometimes

☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

_____

12. do you have any safety concerns for your client / patient in using a bus by themselves (e.g., panic attacks, hills, cognitive deficits, risk of falling, etc.)

☐ Yes ☐ No ☐ Sometimes

☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

_____

13. Are you aware of any visual impairment that may challenge your client / patient in using the city bus?

☐ Yes ☐ No ☐ Sometimes

☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

_____

14.Are you aware of any hearing impairment that may challenge your client / patient in using the city bus?

☐ Yes ☐ No ☐ Sometimes

☐ Do not know

If you have chosen Yes/sometimes, please elaborate:

_____

15. I understand the purpose of this application is to determine if there are times when the applicant cannot use the Charlotte Area Transit System city bus service and may therefore require the CATS Special Transportation program for public transportation needs. I certify that, to the best of my knowledge, the information in this application is true and correct regarding my client/patient. I understand that providing false information may result in penalty under the law.

16. PROFESSIONAL SIGNATURE / NAME: _____