Alameda County City-Based Paratransit Services Application Form

Please use this application if you are a resident of: *Alameda, Albany, Berkeley, Castro Valley, Emeryville, Fremont, Hayward, Newark, Oakland, Piedmont, Pleasanton, San Lorenzo, San Leandro or Sunol.* Upon receipt of this form, the program may contact you to submit additional information. ADA paratransit service operators (East Bay Paratransit, Union City Paratransit & Wheels Dial-A-Ride) require a separate application process. Please return this application to the paratransit program to which you are applying. For more information about specific programs, please refer to the Access Alameda brochure, www.AccessAlameda.org, or call the program directly.

Name: _____
Last Name First Name Middle Initial

Daytime Phone: (____)_____ **Evening Phone:** (____)_____

Cell: (____)_____ **TDD/TTY:** (____)_____ **Email:** _____

Home Address: _____
Street Address Apt. # City Zip Code

Name of Housing Facility (if applicable): _____

Birth Date: ____/____/____ **Male** ❑ **Female** ❑
Month Day Year

Do you manage your own affairs and deal with your own mail? Yes ❑ No ❑
If "No", to whom should important correspondence be directed?

Name: _____ Relationship: _____

Daytime phone: (____)_____ Cell or Evening phone: (____)_____

Email: _____

Mailing Address: _____
(if different from above) Street Address or PO Box Apt. # City State Zip Code

1. **How do you currently travel to your most frequent destinations?** (Check all that apply)
   - ❑ ADA Paratransit (i.e. East Bay Paratransit, Wheels Dial-A-Ride, Union City Paratransit)
   - ❑ Drive myself ❑ Someone drives me ❑ Buses/BART ❑ Taxi
   - ❑ Other: _____

2. **Have you been certified as eligible for rides with an ADA paratransit service? (i.e. East Bay Paratransit, Wheels Dial-A-Ride, Union City Paratransit)**
   - ❑ Fully eligible ❑ Conditionally eligible **Rider Identification #:** _____
   - ❑ Not eligible/Denied ❑ Have not applied ❑ Don't know

3. **Do you use any of the following mobility aids or equipment?** (Check all that apply)
   - ❑ Cane ❑ White Cane ❑ Walker
   - ❑ Manual Wheelchair ❑ Power Wheelchair ❑ Power Scooter
   - ❑ Service Animal ❑ Portable Oxygen Tank ❑ Other: _____

4. **Do you need a wheelchair lift to get in and out of a vehicle?** ❑ Yes ❑ No ❑ Don't know

5. **Do you typically travel with assistance from another person** (other than driver)**?** ❑ Yes ❑ No

6. **Please describe your disability or disabling health condition and explain how this condition prevents you from using public transit** (i.e. buses or BART)**:**

_____

_____

_____

_____

7. **Is the above condition you describe:** ❑ Permanent ❑ Temporary until:_____

8. **Emergency Contact Person:** _____

   Relationship to you: _____ Daytime phone: (____) _____

   Cell phone: (____) _____ Evening phone: (____) _____

9. **Are you on any of the following forms of income/benefit assistance?** *(check all that apply)*
   ❑ Supplemental Security Income (SSI) ❑ Cash Assistance Program for Immigrants (CAPI)
   ❑ Medi-Cal; if yes, #: _____ ❑ CalWorks ❑ General Assistance (GA)

10. **Gross *Individual* Monthly Income:** _____

11. **Gross *Household* Monthly Income:** _____ **# of people in household:** ___

12. **What is your living arrangement?** ❑ Live alone ❑ Live w/ spouse/partner
    ❑ Live with adult children ❑ Live in a skilled nursing facility/nursing home
    ❑ Live in assisted living/residential care home ❑ Other: _____

13. **What is your race/ethnicity?** ❑ African American ❑ Asian/Pacific Islander
    ❑ Caucasian ❑ Hispanic/Latino ❑ Native American
    ❑ Other: _____

14. **What language(s) do you speak?** Preferred Language: _____

    Other Language(s): _____

15. **If you need future information provided to you in an accessible format, please check which format you prefer:** ❑ Large Print ❑ Audiotape ❑ Braille ❑ CD/Electronic File

I certify that the information in this application is true and correct. I understand that knowingly falsifying information will result in denial of service. I give the City permission to contact me about my paratransit service experience and to verify my enrollment with East Bay Paratransit, Wheels Dial-A-Ride or Union City Paratransit. I understand that my application information will be kept confidential; only information required to provide service or verify service quality will be disclosed under any circumstances.

Applicant's Signature: _____ Date: _____

Person who assisted you with application/Phone #: _____

Alameda County City-Based Paratransit Services
Medical Statement Form

This form may need to be completed if the applicant **does not meet the "Senior" age eligibility requirement** of the city-operated paratransit service for which he/she is applying. For more information, please refer to the Access Alameda brochure, www.AccessAlameda.org, or call the program directly.

Applicant's Name: _____ Birthdate: _____

Address: _____

Dear Physician, Social Worker or Health Care Professional:

The above named person is applying for the paratransit services in the city where he or she resides. In order to determine whether this applicant is eligible for paratransit services, applicant must provide verification that he/she is unable to utilize public transit services independently due to a disability/disabling health condition. All information provided below is <u>confidential</u> and is used for the sole purpose of establishing eligibility for paratransit services. Please help us determine the eligibility status of this individual by checking and/or completing all of the items below that apply to applicant. Please return this form to the applicant to submit with his/her paratransit application. Thank you.

1. **Please describe the applicant's disability or disabling health condition that prevents use of public transit *(i.e. buses and/or BART)*:**

   _____

   _____

2. **Applicant's condition is:** ❑ Permanent ❑ Temporary until _____

3. **Due to the conditions noted above, applicant *is <u>unable</u> to use public transit services because he/she:***

   A. _____ Cannot walk or travel in a wheelchair or scooter to or from a bus or train stop without the help of another person
   B. _____ Cannot board or get off a bus or train without the help of someone else
   C. _____ Cannot wait outside by him/herself for a bus or train to arrive
   D. _____ Cannot stand and maintain balance on a moving public transit vehicle
   E. _____ Cannot see, read and/or comprehend information signs, schedules, maps, etc.
   F. _____ Cannot hear and/or comprehend verbal information given by public transit personnel
   G. _____ Other reason(s): _____

4. **Are paratransit services needed for applicant to obtain life-sustaining treatment?** ❑ Yes ❑ No
   (i.e. dialysis, chemotherapy, radiation therapy, etc.)

<u>PRACTITIONER'S STATEMENT:</u> *I hereby state that the information provided above is correct.*

Practitioner's Name: _____ _____
(Print/Type) (Signature)

Date: _____ Discipline: ❑ Physician ❑ Nurse ❑ Social Worker
❑ Other Practitioner (describe): _____

Agency/Organization Affiliation: _____

Address: _____

Telephone #: _____ Fax #: _____ Email: _____