

# East Bay Paratransit

1722 Broadway  
Oakland, CA 94612

## ADA Eligibility Application

### Personal /Contact Information – Please Print

#### Name

\_\_\_\_\_  
Last First Middle  
Daytime Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Evening Phone (\_\_\_\_) \_\_\_\_\_ TDD/TTY (\_\_\_\_) \_\_\_\_\_

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  Female  Male

Primary Language (please check)  English  Other (specify) \_\_\_\_\_

Home Address \_\_\_\_\_  
Number Street Apt.#

City \_\_\_\_\_ Zip Code \_\_\_\_\_

#### Mailing Address if different than above

\_\_\_\_\_  
Street Address or PO Box Apt.#  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_  
Number Street Apt.#

Zip Code \_\_\_\_\_ Phone number (\_\_\_\_) \_\_\_\_\_

#### Emergency contact

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Daytime Phone (\_\_\_\_) \_\_\_\_\_ Evening phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

Phone: (510) 287-5000  
www.eastbayparatransit.org

EBP ADA Application-Interview process-August 2010

**Tell Us About Your Disability / Health Related Condition**

**Please answer the following questions in detail – your specific answers to the questions will help us in determining your eligibility.**

1. What disability or disabling health condition PREVENTS you from using AC Transit and/or BART without the help of another person?

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2. Explain HOW the disability or disabling health conditions you described above prevent you from using AC Transit and/or BART without the help of another person.

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3. When did you first experience the conditions you described above?

- Less than 1 year     1 – 5 years ago     Longer than 5 years

4. Do the conditions you described change from day to day in a way that affects your ability to use AC Transit and/or BART?

- Yes, Could use transit on some days. On other days couldn't.  
 No, doesn't change.  
 Don't know.

5. Are the conditions you described:

- Permanent                       Temporary                       Don't Know

*If temporary, how long do you expect this to continue? \_\_\_\_\_ months.*

**Tell Us About Your Capabilities and Usual Activities**

6. Do you use any of the following mobility aids or specialized equipment?  
*(Check all that apply):*
- |                                          |                                               |                                                |
|------------------------------------------|-----------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> None            | <input type="checkbox"/> Power Wheelchair     | <input type="checkbox"/> Communication Devices |
| <input type="checkbox"/> Cane            | <input type="checkbox"/> Service Animal       | <input type="checkbox"/> Walker                |
| <input type="checkbox"/> White Cane      | <input type="checkbox"/> Crutches             | <input type="checkbox"/> Manual Wheelchair     |
| <input type="checkbox"/> Power Scooter   | <input type="checkbox"/> Portable Oxygen Tank | <input type="checkbox"/> Leg Braces            |
| <input type="checkbox"/> Other Aid _____ |                                               |                                                |
7. How much do you weigh? \_\_\_\_\_
8. Please check the box that best describes your current living situation:
- Live independently (without the assistance of another person)
  - 24 hour care or Skilled Nursing Facility
  - Live with family members who help me
  - Assisted Living Facility
  - Receive assistance from someone that comes to my home to help with daily living activities
9. How far can you walk or travel in your wheelchair or scooter without the help of another person?
- |                         |                        |
|-------------------------|------------------------|
| Less than 1 Block _____ | 3 to 6 Blocks _____    |
| Up to 2 Blocks _____    | 7 or more Blocks _____ |
10. Which of the following statements best describes you if you had to wait outside for a ride? *(Check only one response):*
- I could wait by myself for ten to fifteen minutes.
  - I could wait by myself for ten to fifteen minutes only if I had a seat and shelter.
  - I would need someone to wait with me because \_\_\_\_\_
- 
11. Which of the following statements best describes you?  
*(Check only one response):*
- I have never used AC Transit and/or BART.
  - I have used AC Transit and/or BART but not since the onset of my disability / health condition.
  - I have used AC Transit and/or BART within the last six months.

**Tell Us About Your Travel Needs**

12. How do you currently travel to your frequent destinations? Check all that apply.

- Buses AC Transit or Program bus (circle the one you use).  
How many times per month? \_\_\_\_\_
- BART How many times per month? \_\_\_\_\_
- Paratransit East Bay, City or other program (circle the one you use).  
How many times per month? \_\_\_\_\_
- Taxi Scrip Program or full fare (circle the one you use).  
How many times per month? \_\_\_\_\_
- Drive myself How many times per month? \_\_\_\_\_
- Someone drives me How many times per month? \_\_\_\_\_

13. Can you get to and from the AC Transit stop nearest your house by yourself?

- Yes  No  Sometimes  Don't know where the stop is

If no or sometimes, check why:

- Hills  Curbs  No Sidewalks  Weather
- Distance to the stop  Street Crossings

14. Can you grasp handles, railings, coins, and tickets?

- Yes  No  Sometimes  Don't know, never tried it

If no or sometimes, explain why:

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15. Can you stand and maintain balance on a moving AC Transit Bus or BART Train when holding onto a pole or railing ?

- Yes  No  Sometimes  Don't know, never tried it

If no or sometimes, explain why:

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**East Bay Paratransit ADA Eligibility Application**

16. Please provide the address of the places you travel to most often.  
(i.e. Medical, Physical Therapist, Stores, and other places)

Place	Address	City	Telephone Number (if known)

17. Please add any other information that you would like us to know about your abilities or disabilities.

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18. East Bay Paratransit provides material in alternative forms to people whose disability prevents them from reading printed materials. If you qualify, check which format you prefer:

- Email    Print email address: \_\_\_\_\_
- Braille
- CD audio recording
- CD text file
- Audio tape

19. Do you receive Medi-Cal?  Yes  No  
If yes, please provide your Medi-Cal number: \_\_\_\_\_

# Certification for Personal Care Attendant

A personal care attendant is someone whose help you need for daily life activities (eating, dressing, personal hygiene, finding your way, etc.). An attendant does not always have to be the same person.

East Bay Paratransit drivers are not personal care attendants, nor does East Bay Paratransit provide attendants.

Do you travel with a personal care attendant?  Yes  No  Sometimes

If yes or sometimes, complete the all of the information below and sign. **East Bay Paratransit reserves the right to contact your health care professional to verify your need for an attendant.**

Please Print

Your Name \_\_\_\_\_

Explain how your attendant helps you \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Verification

I certify that due to my disability, I require the services of a personal care attendant to assist me on a regular basis and travel with me on East Bay Paratransit. **I understand that fraudulently claiming to travel with an attendant to avoid paying a fare for a companion may result in suspension of service.**

Signature \_\_\_\_\_ Date \_\_\_\_\_



## Applicant Certification

I **certify** that the information in this application is **true** and **correct**. I understand that knowingly falsifying the information will result in denial of service. I understand all information will be kept confidential, and only the information required to provide the services I request will be disclosed to those who perform the services.

**I understand that it may be necessary to contact a professional familiar with my functional abilities to use AC Transit or BART in order to assist in the determination of eligibility.**

Signed by: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Relationship (if person other than applicant ) \_\_\_\_\_

**Did someone help you in filling out this form?**

Yes

No

Can we contact this person for additional information?

Yes

No

If the person who helped you fill out this form did not sign above, please provide the following information:

Name \_\_\_\_\_ Phone number (\_\_\_\_) \_\_\_\_\_

Relationship \_\_\_\_\_

Please Note: It is your responsibility to notify us if your disability improves enough to change your eligibility status. If your condition improves after you have been determined eligible or we discover you submitted false information, your eligibility could be suspended or you may be asked to re-apply.

**Now, please pick up the phone and call 510 287-5000 to set up your interview. Press 5 when you hear the recorded message. Bring your completed and signed ADA application to your interview.**