

Roundup-Application.pdf

Letterhead Departments

Dear Applicant,

CLOVIS TRANSIT

155 N. SUNNYSIDE AVE., CLOVIS, CA 93611

Thank you for inquiring about Clovis Transit Round Up paratransit service. As part of the ADA (Americans with Disabilities Act), paratransit service is

provided to persons who are unable to independently use regular public transit due to a disability or health-related condition.

In order to use Round Up, you must be certified as eligible. Having a disability does not automatically qualify you for paratransit eligibility. In addition,

eligibility is not a medical decision or something your medical professional can prescribe for you. Age, lack of experience riding the regular bus, and/or

inability to drive are not disabilities. Situations like these are not used to determine Round Up eligibility.

Paratransit eligibility is based on your functional ability to use the Stageline fixed route service.

Determinations are made based on bus riding limitations

caused by your disability(ies). You may qualify for unconditional (full) or conditional (partial) service.

Please read the attached Round Up Overview before you start the application process. When you have completed the application in its entirety, return it

by mail or fax it to our office. Both sections of the application are required before an assessment will be made. You will be notified by mail within 21

days of your eligibility status.

Any questions about the application or the Round Up service should be directed to Clovis Transit Round Up at 559-324-2760.

Sincerely,

Clovis Transit

Round Up provides many travel opportunities for riders with disabilities, however it does have its limitations. Before you apply for Round Up, please be

aware of what it can and can't do for you:

Round Up Overview

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list of 9 items

- ☒ Advance reservations are required. No same day requests.
- ☒ Your requested time may not be available. Trips can be offered an hour before or an hour after what you request.
- ☒ The scheduler will give you a be-ready time. The driver has a 15-minute window from this time to pick you up.
- ☒ You must be ready to board the bus when the driver arrives. The driver waits five minutes and then will leave.
- ☒ Round Up is a shared ride service. You may be on the bus with other riders.
- ☒ You are allowed one PCS (personal care attendant) to ride free of charge. Companions pay the full fare.
- ☒ Drivers do not enter a rider's residence. If door-to-door service is requested, the driver will meet the passenger at the threshold of the door.
- ☒ Drivers do not sign passengers in or out of facilities.
- ☒ Round Up is not an emergency service.

list end

STEPS IN THE APPLICATION PROCESS

list of 3 items

1. Complete the entire Applicant section. It must be signed by the applicant or the applicant's guardian and anyone who assisted completing the form.
2. Submit your application to your physician or other health care professional to complete the Professional Verification section.
3. Detach this cover letter and keep it for your records.

list end

list of 1 items

4. Mail or fax your completed and signed form to:

list end

Clovis Transit Round Up 155 N. Sunnyside Avenue Clovis, CA 93611

Fax: 559-324-2853

Your complete application will be processed within 21 days after it has been received. You will receive notice of eligibility or non-eligibility by mail.

DATE RECVD: FOR TRANSIT STAFF ONLY: EXPIRATION DATE:

687

Round Up Eligibility Application

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Complete all parts of the form. Incomplete forms will be returned.

Please print or type Male Female

PART 1 – Applicant Data

710

Name:

Last First M.I.

Street Address: Apt.#:

City: Zip Code:

Home Phone: () Cell Phone: ()

Birth Date: / / . Email Address:

Would you prefer message alerts by text or by email?

Mailing Address (if different from above)

Street Address: Apt.#:

City: Zip Code:

Emergency Contact Person

Name: _ Relationship: _____

Day Telephone: () Evening Telephone: ()

What is your disability?

780

Explain how your disability prevents you from independently using the regular city bus (Stageline).

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1. Which of the following assistive devices, if any, do you use?

(Please check all that apply.)

Cane Powered Wheelchair Manual Wheelchair

White Cane Powered Scooter/Cart Prosthesis

Walker Communication Aid Portable Oxygen

Crutches Service Animal

Other (please describe):

If you selected Wheelchair or Scooter, would you prefer/need to use the device while riding in Round Up vehicles? Yes No Sometimes

2. Are you able to travel in a minivan? Yes No

3. If you use a wheelchair or scooter:

Is it more than 30 inches wide? Yes No

Is it more than 48 inches long? Yes No

Is the combined weight of device and occupant more than 600 pounds?

Yes No

4. Does your health condition/disability require you to use Round Up service:

Permanently Temporarily Week(s) Month(s)

5. Does your health condition/disability change from day to day in ways that occasionally disrupts your ability to use regular-route city bus service?

Yes No If yes, please explain:

PART 2 – Using Regular-Route Public Transit

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Complete Part 2 even if you are unable to use regular-route city bus service. This information will assist us in determining how your disability/health

condition affects your ability to use regular-route city bus service.

1. Do you now independently use regular-route city buses?

Yes No Sometimes Yes, but only with an attendant

If "Yes" or "Sometimes," how many times? _____per week _____per month

Which of the following best describes how you use regular-route city buses?

To travel to and from one destination only

To travel to and from a few destinations

To travel to and from many different destinations

2. Have you ever had training to use the regular-route city buses? Yes No

3. What is the maximum distance you are able to travel without the assistance of another person?

less than 1 block 1-3 blocks 4-6 blocks more than 6 blocks

(<110 yards) (110-330 yards) (440-660 yards) (more than 661 yards)

4. I can wait for a regular-route city bus (check all that apply):

Only if there is a bench or shelter Up to 15 min. More than 15 min.

list of 1 items

5. Please check all the categories below as they relate to your ability to use regular-route city buses:

list end

table with 5 columns and 10 rows

I am:

Yes

No

Sometimes

A.

Able to tolerate hot or cold weather (rain, humidity)

B.

Able to recognize destinations, bus stops, or landmarks

C.

Able to tolerate air pollution (smog, fumes, perfume)

D.

Free from night blindness (bright light, low light)

E.

Able to recognize printed information

F.

Able to hear and process spoken words or auditory information (background noise)

G.

Able to communicate needs

H.

Able to follow directions

I.

Able to deal with unexpected situations or changes in routine (example: bus detours)

table end

table with 5 columns and 11 rows

J.

Able to safely and effectively travel through crowded and/or complex facilities

K.

Able to recognize and navigate curbs, drop-offs, curb cuts and other barriers

L.

Able to travel independently along sidewalks and other pedestrian ways

M.

Able to cross streets independently

N.

Able to find the correct bus stop

O.

Able to identify the correct bus (single or multiple buses during a single trip)

P.

Able to get on and off a bus using the lift if necessary

Q.

Able to deposit fare into the fare box or show bus pass

R.

Able to get to a seat/wheelchair position

S.

Able to ride in a standing position

T.

Familiar with what to do if I miss my bus

table end

If you checked "No" or "Sometimes" to any of the items in question 5, please explain:

1183

Please list the addresses commonly traveled to:

Street Address: Suite.#:

City: Zip Code:

Street Address: Suite.#:

City: Zip Code:

Street Address: Suite.#:

City: Zip Code:

Applicant Certification

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I understand the information I provided on this application is true and correct to the best of my knowledge. The purpose of this application is to determine

if I am eligible to use Round Up paratransit services, or if at times I can ride the Stageline fixed-route buses. I understand that falsification of information

could result in a loss of Round Up services as well as a penalty under the law.

I also understand that, at no expense to me Clovis Transit may require that I participate in an in-person functional evaluation of my travel skills and

agree to such a functional evaluation if one is necessary. Additional information will be required only when the information provided on the application

does not clearly determine ADA paratransit eligibility.

I agree to notify Clovis Transit if my condition changes, if my mobility device has been replaced, if I have a new mobility device, or if I no longer need

to use Round Up service.

Applicant Signature Date

*If the applicant is not his/her own guardian, the following information about the guardian is required.

Guardian's Name First Middle Initial Last

_____ Day Phone Signature and Date

*If someone other than the applicant or applicant's guardian prepared this form, please provide the following information about the preparer.

Preparer's Name First Middle Initial Last

Relationship to Applicant

Day Phone Signature and Date

1. Complete and sign the "Authorization to Release Information". If the applicant does not sign it, the form will be returned for a signature.*

PART 4 – Round Eligibility Professional Verification

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list of 1 items

2. Send to your designated professional.

list end

list of 1 items

3. Wait for the professional to return the Professional Verification Form to you. Check back with your professional if you don't receive your information.

list end

list of 1 items

4. Put your Eligibility Application and Professional Verification forms together and send to:

list end

Clovis Transit Round Up

155 N. Sunnyside Ave., Clovis, CA 93611

Facsimile: (559) 324-2853

SECTION A Authorization to Release Information

(When complete, send to the professional you named)

I authorize the following professional to release Round Up specific information as requested. 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 revoked, this form will

allow that professional listed below to release information described for six months after the date appearing below.

Name of Professional: _____ Title: _____

Applicant's Name: _____

Date of Birth: ____/____/____

Applicant's Address: _____ Apt.# _____

City: _____ State: _____ Zip Code: _____

Applicant's Telephone Number: (____) _____

*APPLICANT'S SIGNATURE: _____ Date: _____

Guardian's signature required if the applicant is not his/her own guardian,

Guardian's Signature: _____ Date: _____

1512

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This concludes the applicant's portion of the application. The following pages MUST be completed by a health care professional.

Both sections must be received by Clovis Transit before an evaluation will be made.

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[This page intentionally left blank.]

SECTION B Mobility Professional Verification Form

This section must be completed by a licensed medical professional.

Dear Health Care Professional:

The Federal Law is very specific about ADA Para-transit eligibility. You are being asked to provide information regarding this individual's disability.

Eligibility is restricted to individuals who,

list of 2 items

1. As a result of their disability, cannot board, ride, or disembark from a regular fixed route bus.
2. Have a specific impairment related condition which prevents them from getting to or from a bus stop.

list end

PLEASE NOTE: This does not include persons who find it difficult or uncomfortable to get to and from bus stops.

In providing information you should consider only the presence of a disability or health condition and not the applicant's age or economic status.

You will be asked to include your credentials on page 10.

GENERAL INFORMATION (Must be completed for all applicants)

Describe diagnosed disability you are currently treating this individual for and the functional limitations of this impairment: _____

Date of onset ____/____/____ Date of last visit ____/____/____

How long have you worked with individual? Since ____/____/____

Is disability temporary _____ or permanent _____?

If permanent, is disability progressive? Yes No

If temporary please give best estimate of rate of recovery _____

Do temperature extremes affect the individual? (Ex. Heat index of more than 85 degrees or wind chill less than 32 degrees) Yes No

If yes, how so? _____

Please list all medications _____

Is this individual compliant with taking medications? Yes No

Can the individual currently use regular route public transportation? (all buses are equipped with wheelchair lifts)

Yes No Not Sure

Does the individual's health condition/disability require they travel with someone to assist and/or supervise them? Yes No

Is the individual's judgment impaired? Yes No

Is behavioral inhibition impaired? Yes No

Can the individual walk? Yes No

Does the individual use a wheelchair or mobility aid? Yes No

Please list _____

How long has the individual been using the device(s)? _____

What is the maximum distance the individual is able to travel without the assistance of another person?

less than 1 block 1- 3 blocks 4-6 blocks more than 6 blocks

(<110 yards) (110-330 yards) (440-660 yards) (more than 660 yards)

table with 5 columns and 11 rows

Is/ Can/ Does the individual:

Yes

No

Sometimes

A

Able to live independently

B.

Able to seek and ask directions

C.

Able to process information

D.

Able to follow routines (consistency)

E.

Have basic coping skills

F.

Have basic judgment skills

G.

Have basic problem solving skills

H.

Have basic orientation skills (person, place, time)

I.

Have any concentration limitations

J.

Have any short or long term memory limitations

table end

VISUAL IMPAIRMENT

(Please complete if applicable to patient's disability)

Please provide visual acuity measurements and visual field readings for both eyes.

OS _____ OD _____

EMOTIONAL/BEHAVIOR ISSUES

Does the individual experience any of the following:

Auditory hallucinations Visual hallucinations Delusions

Disassociation

Does this prevent the individual from being oriented to person, place, and time?

Yes No

Is the individual currently being treated for any of the following:

Anxiety Depression Panic attacks Schizophrenia

Other: _____

For anxiety panic attacks please indicate on average the frequency and length of panic attacks. ____ per day ____ per week ____ per month

____ per year _____ approx. duration

PLEASE PRINT SO THAT WE MAY CONTACT YOU IF NEEDED

Name of Professional: _____

Title: _____ Professional License # : _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax: _____

Doctor/Health Care Professional Signature: _____

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Please provide any additional information which may assist us in determining this applicant's eligibility:

2010

Handy Ride staff will make the final determination on the applicant's eligibility.

Round Up staff will make the final determination on the applicant's eligibility.