



# CITY *of* CLOVIS

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CLOVIS TRANSIT

155 N. SUNNYSIDE AVE., CLOVIS, CA 93611

Dear Applicant,

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 Overview

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:

- 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.
- 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.

## STEPS IN THE APPLICATION PROCESS

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

**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:

# Round Up Eligibility Application

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

## PART 1 – Applicant Data

Please print or type

Male  Female

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?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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.)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Cane                           | <input type="checkbox"/> Powered Wheelchair   | <input type="checkbox"/> Manual Wheelchair |
| <input type="checkbox"/> White Cane                     | <input type="checkbox"/> Powered Scooter/Cart | <input type="checkbox"/> Prosthesis        |
| <input type="checkbox"/> Walker                         | <input type="checkbox"/> Communication Aid    | <input type="checkbox"/> Portable Oxygen   |
| <input type="checkbox"/> Crutches                       | <input type="checkbox"/> Service Animal       |  |
| <input type="checkbox"/> 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

*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 (<110 yards)     1-3 blocks (110-330 yards)     4-6 blocks (440-660 yards)     more than 6 blocks (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.

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

| I am:   | Yes                      | No                       | Sometimes                |
|---|--------------------------|--------------------------|--------------------------|
| A. Able to tolerate hot or cold weather (rain, humidity)                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Able to recognize destinations, bus stops, or landmarks                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Able to tolerate air pollution (smog, fumes, perfume)                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Free from night blindness (bright light, low light)                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Able to recognize printed information  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Able to hear and process spoken words or auditory information (background noise)     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Able to communicate needs  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Able to follow directions  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I. Able to deal with unexpected situations or changes in routine (example: bus detours) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

|   |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|
| J. Able to safely and effectively travel through crowded and/or complex facilities  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| K. Able to recognize and navigate curbs, drop-offs, curb cuts and other barriers    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| L. Able to travel independently along sidewalks and other pedestrian ways           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| M. Able to cross streets independently  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| N. Able to find the correct bus stop  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| O. Able to identify the correct bus (single or multiple buses during a single trip) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| P. Able to get on and off a bus using the lift if necessary                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Q. Able to deposit fare into the fare box or show bus pass                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| R. Able to get to a seat/wheelchair position  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| S. Able to ride in a standing position  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| T. Familiar with what to do if I miss my bus  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

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Please list the addresses commonly traveled to:

Street Address: \_\_\_\_\_ Suite.#: \_\_\_\_\_  
City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Street Address: \_\_\_\_\_ Suite.#: \_\_\_\_\_  
City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

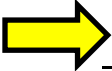
Street Address: \_\_\_\_\_ Suite.#: \_\_\_\_\_  
City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Applicant Certification**

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

**PART 4 – Round Eligibility Professional Verification**

- 1. **Complete and sign** the “*Authorization to Release Information*”. If the applicant does not sign it, the form will be returned for a signature.\*
- 2. **Send** to your designated professional.
- 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.
- 4. **Put your Eligibility Application and Professional Verification forms together and send to:**

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:* \_\_\_\_\_





**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.**

**SECTION B**                      **Mobility Professional Verification Form**

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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,**

- 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.**

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)*

Patient Name: \_\_\_\_\_

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 1block (<110 yards)     1- 3 blocks (110-330 yards)     4-6 blocks (440-660 yards)     more than 6 blocks (more than 660 yards)

| Is/ Can/ Does the individual:                          | Yes                      | No                       | Sometimes                |
|--|--------------------------|--------------------------|--------------------------|
| A. Able to live independently                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Able to seek and ask directions                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Able to process information                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Able to follow routines (consistency)               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Have basic coping skills                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Have basic judgment skills                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Have basic problem solving skills                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Have basic orientation skills (person, place, time) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I. Have any concentration limitations                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| J. Have any short or long term memory limitations      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## **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:** \_\_\_\_\_

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

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