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).

____

____

____

____

____

____

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

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)	☐	☐	☐
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)	☐	☐	☐

		☐	☐	☐
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	☐	☐	☐

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

____

____

____

____

Please list the addresses commonly traveled to:

Street Address: ______________________________Suite.#:_________

City: ______________________________Zip Code:_________________

Street Address: ______________________________Suite.#:_________

City: ______________________________Zip Code:_________________

Street Address: ______________________________Suite.#:_________

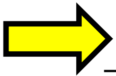
City: ______________________________Zip Code:_________________

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
785 Third St., Clovis, CA 93612
Facsimile: (559) 297-1034

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

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

	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	☐	☐	☐

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:

____

____

____

____

____

____

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