REGIONAL TRANSPORTATION DISTRICT

APPLICATION FOR ADA PARATRANSIT

If you are a first-time applicant:

☐ **New** admin only ( )

If you are re-applying for services:

☐ **Recertification (ID #)**

Release Date (mm/dd/yyyy)

Name
Last Name First Name Middle Initial

Address **Apt #**

Name of Apartment Complex or Facility

City **County** **State** **Zip**

Primary phone: ( ) - ☐home ☐cell ☐work

Secondary phone: ( ) - ☐home ☐cell ☐work

Birth Date: ☐Male ☐ Female

E-Mail:

Primary language: Will you need translation? ☐Yes ☐No

If yes, how can we assist?

Mailing Address (if different):

Address Apt #

City County State Zip

If you will need future written information in a different format, please let us know your preference:

<u>Local Emergency Contact:</u>

Name Relationship

Primary phone: ( ) - ☐home ☐cell ☐work

Secondary phone: ( ) - ☐home ☐cell ☐work

Name/relationship of person assisting with completion of this form:

Please let us know why you are applying for Access a Ride service:

☐ I have never used or I don't know how to use fixed route bus and rail service and/or can no longer drive or have no one to drive me

☐ I use fixed route bus and rail services regularly

☐ I use regular fixed route bus and rail to go some places, but not others

☐ I can never use regular fixed route bus and rail because:

If someone were to assist you as you travel, assistance would be needed for:

Getting to/from bus stops/rail stations: ☐ Always ☐ Never ☐ Sometimes

Getting on/off the bus or train: ☐ Always ☐ Never ☐ Sometimes

Knowing where you need to go: ☐ Always ☐ Never ☐ Sometimes

Other (please describe):

How do you currently travel?

☐ Drive myself ☐ Cab ☐ Access-a-Ride

☐ Someone drives me ☐ Bus ☐ Other

☐ Uber/Lyft ☐ Rail

What is the closest major intersection to your home?

How far is the nearest bus/rail stop from your home?

Are you able to travel to this bus/rail stop? ☐ Yes ☐ No

If no, what prevents you from doing so?

Which routes do you regularly travel?

When was the last time you used the fixed route bus/rail?

If you used to use fixed route service and no longer do, please explain why?

Which disability or health-related conditions PREVENT you from using regular public transit without the help of another person?

When did you first experience the conditions described above?
☐ 0-1 years ago ☐ 1-5 years ago ☐ more than 5 years ago

Are these conditions: ☐ Permanent ☐ Temporary (if so, for how long?)

Are the effects of these conditions variable from day to day? ☐ Yes ☐ No

Do your health-related conditions inhibit your ability to perform self-care tasks or tasks related to living independently? ☐ Yes ☐ No

Are you able to:

Read a bus and/or rail schedule?	☐ Yes	☐ No
Contact the RTD help line to consult with trip planning?	☐ Yes	☐ No
Wait 15 min at a stop?	☐ Yes	☐ No
Determine bus fare?	☐ Yes	☐ No
Place the fare/pass in the box?	☐ Yes	☐ No
Find a seat on the bus?	☐ Yes	☐ No
Recognize landmarks?	☐ Yes	☐ No
Follow directions in an emergency?	☐ Yes	☐ No
Determine a new plan when you make a mistake?	☐ Yes	☐ No

If no for any of the above, please explain:

Which of the following mobility aids do you use when you take trips using public transportation? (Please check all that apply)

☐ None	☐ Power wheelchair	☐ Prosthesis
☐ Cane	☐ Power scooter	☐ Walker
☐ White cane	☐ Extra-large wheelchair	☐ Crutches
☐ Portable oxygen	☐ Communication board	☐ Other:
☐ Manual wheelchair	☐ Service animal	

It is your responsibility to bring the checked devices to your assessment appointment.

When traveling out of your home using your most frequently used device, are you able to:

Cross a busy intersection once you get off the bus?	☐ Yes	☐ No
Reach your destination once you get off the bus?	☐ Yes	☐ No
Travel up/down hills?	☐ Yes	☐ No
Travel in areas without curb cuts?	☐ Yes	☐ No
Travel at night?	☐ Yes	☐ No
Travel in cold weather?	☐ Yes	☐ No
Travel in hot weather?	☐ Yes	☐ No
Travel in bright light conditions?	☐ Yes	☐ No
Travel when it is raining or snowing?	☐ Yes	☐ No
Have you ever had travel training?	☐ Yes	☐ No
Would you like information on travel training services?	☐ Yes	☐ No

I certify that the information provided in this application is true and correct.

I understand that falsification of information could result in a loss of Access-a-Ride services.

Signature **Date**

REGIONAL TRANSPORTATION DISTRICT

ACCESS-A-RIDE PROFESSIONAL MEDICAL VERIFICATION FORM

Health care providers who can complete this form (must be treating the disability for which applicant is applying for paratransit service):

Physician	PT / OT	Registered Nurse
Psychiatrist	Orientation & Mobility Specialist	Social Worker (MSW)
PA/NP	Respiratory Therapist	Mental Health Clinician
Psychologist	Optometrist	Rehabilitation Counselor
Ophthalmologist	Chiropractor	

Name/Credential of Professional:

License Number of Professional:

Phone Number:

The Americans with Disabilities Act of 1990 (1990) is a civil rights act that requires public transit agencies to provide Paratransit service to people whose disabilities prevent them from using a bus some or all the time. The information you provide will enable us to make an appropriate determination for this applicant. All information will be kept confidential. Thank you for your assistance.

Access-a-Ride service is designed for individuals who are unable to utilize the fixed route bus and rail system due to:

a) physical, cognitive or visual impairments that require assistance from another person

b) impairments related to accessible travel to/from embarking locations

Authorization for Release of Information

I hereby authorize the above-named professional to provide information about my disability and abilities to use bus service to the Regional Transportation District (RTD) and/or persons assisting RTD in determining my eligibility for Access-a-Ride service. I understand that this information will be used solely for the purpose of determining my eligibility for Access-a-Ride service and that all medical information about my disability will be kept confidential.

I also understand that, at no expense to me, RTD will require that I participate in an in-person evaluation of my travel skills and agree to such an evaluation.

Signature of Applicant or Responsible Party

Date

***

MEDICAL VERIFICATION FORMS LACKING A SIGNATURE AND LICENSE NUMBER MAY NOT BE PROCESSED

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Please return this form to the applicant once it is completed.

Name of applicant:

Please reflect on the functional capacity of your patient with regard to use of fixed route bus and rail service:

1. How long has this applicant been under your care?
2. Most recent visit date**:**
3. Does the applicant's disability prevent the applicant from getting to / from and riding the bus / light rail system? ☐Yes ☐Sometimes ☐No
4. If yes or sometimes, please explain how the applicant's disability or health related conditions prevent use of the public bus / light rail system:
5. Does this applicant need someone to accompany him/her at all times? ☐Yes ☐No
6. **Does the applicant have the mental capacity, visual and/or hearing ability to:**
   - Ask for, understand and follow directions? ☐Yes ☐No
   - Ask for assistance from appropriate sources? ☐Yes ☐No
   - Safely cross a major street? ☐Yes ☐No
   - Safely travel through crowded/complex facilities? ☐Yes ☐No
   - Recognize a destination or landmark? ☐Yes ☐No
   - Signal a bus operator to get off at destination stop? ☐Yes ☐No
   - Filter environmental noise? ☐Yes ☐No
   - Judge traffic flow? ☐Yes ☐No
7. **Regarding vision impairments only:** ☐N/A
   - Is the applicant able to locate steps or curbs? ☐Yes ☐No
   - Is the applicant impacted by bright sunlight? ☐Yes ☐No
   - Is the applicant limited by dimly lit conditions? ☐Yes ☐No
   - Is the applicant's vision impacted at night? ☐Yes ☐No
8. **Regarding this applicant's mobility, USING THEIR MOBILITY AID, is applicant able to independently:**
   - Travel outdoors on their property? ☐Yes ☐No
   - Travel up to 1 block? ☐Yes ☐No
   - Travel up to 3 blocks? ☐Yes ☐No
   - Stand for up to 15 minutes with support? ☐Yes ☐No
   - Stand for up to 15 minutes without support? ☐Yes ☐No
   - Travel up or down hills? ☐Yes ☐No
9. **These impairments are:**
   ☐Stable ☐Progressive ☐Degenerative ☐Temporary, duration:
10. Does weather impact the applicant's ability to travel? ☐No ☐**Wind**
    Cold ☐<30^0 ☐<40^0 ☐<50^0 **Heat** ☐>70^0 ☐>80^0 ☐>90^0

Signature of Provider **Date**

REGIONAL TRANSPORTATION DISTRICT

APPLYING FOR ACCESS-A-RIDE SERVICES

IN ORDER TO PREVENT DELAYS IN YOUR APPLICATION, PLEASE FOLLOW THESE INSTRUCTIONS:

1. **Save a copy of the application to your computer**
2. **Complete this application**
3. **Print the application**
4. **Ask your Medical Provider who is familiar with your disability to complete the Medical Verification Form (attached)**
5. **Mail both *completed* forms (6 pages) to RTD at:**

   RTD
   c/o Access-a-Ride
   1660 BLAKE ST
   DENVER, CO 80202

Please Note: The in-person assessment will not be scheduled until the completed application and medical form have been received by RTD.

PLEASE LET US KNOW IF YOU WILL REQUIRE A LANGUAGE INTERPRETER FOR THE ASSESSMENT

THE DAY OF THE ASSESSMENT:

1. Wear clothing appropriate for the weather
2. Bring the mobility aids that you use (or will use) on public transportation.
   Note: *our vehicles are unable to accommodate a combined weight of more than 800 pounds*
3. Your photo ID card
4. Bring someone to assist you if you need assistance with personal care tasks
5. If you use oxygen, bring enough for at least 3 hours.
6. Bring a snack if you feel you might need one.
7. Bring medications that you might need to take during the time you are away. (up to 3 hours)