APPLICATION

If you have a physical or functional disability as defined by the Americans with Disabilities Act (ADA), which limits you from using Omnitrans fixed route accessible buses, you may be eligible for Access Service. The information obtained in this certification process will be used by Omnitrans to determine your eligibility for Access. The information may be shared with other transit providers to facilitate your travel in other areas.

This application must be **filled out completely**, including the verification form completed by a qualified healthcare professional. Incomplete applications will cause your eligibility process to become delayed.

NAME _____
First MI Last

BIRTHDATE ___/___/_____ SOCIAL SECURITY NUMBER (optional) _____ - ____ - _____

MEDI-CAL NUMBER (if applicable) _____

HOME ADDRESS _____
Street APT#

_____
City State ZIP

PHONE _____
Home Cell Work

MAILING ADDRESS _____
(if different than above) Street Apt# City State Zip

Neighborhood Environment

How would you describe the area where you live (e.g., very steep hill; long gradual hill; flat; etc.)?

_____

Are there sidewalks at your residence? _____ Yes/No Is there a ramp at your residence? _____ Yes/No

How many steps are there at the entrance to your residence? _____

Do you live on the ground floor? _____ Yes/No

Current Transportation

Do you use the regular Omnitrans buses now? _____
Yes / No / Sometimes

If no or sometimes, what limits or prevents you from riding the buses? (e.g., no sidewalks)

_____

What is the most difficult part of riding the bus for you? _____

_____

What bus routes serve your neighborhood? _____

_____

What is the closest bus route to your home? (Please give location) _____

_____

Can you get to the bus stop by yourself? _____
Yes / No / Sometimes

If not, why not? _____

Can you board the bus by yourself? _____
Yes / No

If not, why not? _____

Have you ever received any training to use the fixed route bus service? _____
Yes / No

If not, would you like to participate in free training? _____
Yes / No

If you do not ride Omnitrans buses: how do you currently travel? (for example, family, friends, etc.)

_____

Mobility Devices Used

(check all that apply)

___ **Manual Wheelchair**
- ___ Foldable; passenger is able to transfer to a standard seat without driver assistance.
- ___ Passenger is not able to transfer to a standard seat without driver assistance.

___ High Wheelchair	___ Cane/White Cane	___ Walker (foldable)
___ Long Wheelchair	___ Crutches	___ Walker (non-foldable)
___ Electric Wheelchair	___ Wide Wheelchair	___Oxygen Tank
___ Stroller-Type Chair	___ Power Scooter	___ Prosthetics
___ Certified Service Animal	___ Braces	___ Other _____

Preferred Media / Communication Type

___ Regular Print ___ Large Print ___ Braille

___ Cassette Tape ___ Computer CD ___ TDD/California Relay

___ Other (please specify) _____ ___ Espanol

___ Email (please give address) _____

OMNITRANS ACCESS APPLICANT AGREEMENT

I agree that if I am certified for Omnitrans Access Service, I will pay the exact fare, if required, for each trip. I agree to notify the Omnitrans Eligibility office of any changes in my status which may affect my eligibility to use the service. I also understand that failure to adhere to the Omnitrans Paratransit Policies and procedures will be grounds for revocation of my eligibility and the right to participate in the program.

I understand and agree to hold Omnitrans Access harmless against all claims or liability for damages to any person, property, or personal injury occurring as a result of my failure to equip or maintain the safety of the adaptive equipment or service animal that I require for mobility. I have read and fully understand the conditions for service outlined in the Omnitrans Access Paratransit Policies and agree to abide by them.

I hereby authorize the release of verification information and any additional information to Omnitrans for the purpose of evaluating my eligibility to participate in the Access Program.

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

Signature Date

The following information is to be filled out if the application was completed by a person other than the applicant:

NAME _____ DAYTIME PHONE _____

ADDRESS _____

Street Apt# City State Zip

Signature Date

Emergency Contact

NAME

Relationship Phone Number

ADDRESS

Street Apt# City State Zip

This page and the following 2 pages must be completed by a <u>Qualified Licensed Healthcare Professional</u> (PLEASE PRINT).

OMNITRANS ACCESS SERVICE

Verification of Eligibility

Please note: All information for verification of eligibility must be provided by a qualified licensed professional. Examples of qualified licensed professionals are but not limited to:

Physician	Psychiatrist	Psychologist	Chiropractor
Ophthalmologist	Registered Nurse	Social Worker	

PERSON COMPLETING VERIFICATION _____

PROFESSIONAL TITLE _____

AGENCY/AFFILIATION _____

LICENSE NUMBER _____

BUSINESS ADDRESS _____
Street Unit # City State Zip

BUSINESS TELEPHONE _____

*****IF YOU MARK NO OR SOMETIMES TO ANY ITEM BELOW, PLEASE EXPLAIN*****

1. What is the medical diagnosis that causes the disability (e.g., intellectual disability, epilepsy)?

_____

_____

Is this condition temporary? ___ Yes ___ No

If yes, expected duration-until: _____
Date of Duration

2. Does the applicant's disability require that he or she travel with an attendant?

___ Yes ___ No ___ Sometimes

Explain: _____

3. Is there any other medical information Omnitrans Access should know in the event of an emergency? (e.g., Hepatitis, Tuberculosis) _____

_____

4. If the client has a disability affecting mobility, is he or she:
   able to travel a distance of 200 feet without assistance? ___ Yes ___ No ___ Sometimes
   Explain: _____
   _____
   able to travel a distance of 3 blocks (1/4 mile) without assistance over different types of terrain? ___ Yes ___ No ___ Sometimes
   Explain: _____
   _____

   able to travel a distance of 6 blocks (1/2 mile) without assistance over different types of terrain? ___ Yes ___ No ___ Sometimes
   Explain: _____
   _____
   able to wait outside without support for 15 – 30 minutes in different weather conditions?
   ___ Yes ___ No ___ Sometimes Explain: _____
   _____

   able to cross: ___ 2-way stop ___ 4-way stop
   able to cross traffic light-controlled intersections in the following areas:
   ___ residential ___ semi-business ___ business

5. If vision impaired, what is the Best Corrected Acuity? Right _____ Left _____
   Field Restriction: Right _____ Left _____

   If legally blind, is he or she
   able to travel a distance of 200 feet without assistance? ___ Yes ___ No ___ Sometimes
   Explain: _____
   _____
   able to travel a distance of 3 blocks (1/4 mile) without assistance over different types of terrain? ___ Yes ___ No ___ Sometimes
   Explain: _____
   _____

   able to travel a distance of 6 blocks (1/2 mile) without assistance over different types of terrain? ___ Yes ___ No ___ Sometimes
   Explain: _____
   _____
   able to wait outside without support for 15 – 30 minutes in different weather conditions?
   ___ Yes ___ No ___ Sometimes Explain: _____
   _____

   able to cross: ___ 2-way stop ___ 4-way stop
   able to cross traffic light-controlled intersections in the following areas:
   ___ residential ___ semi-business ___ business

6. If the person has a cognitive disability, is he or she able to:

   give name, address, and telephone numbers upon request? ___ Yes ___ No ___ Sometimes

   Explain: _____
   recognize a destination or landmark? ___ Yes ___ No ___ Sometimes

   Explain: _____
   deal with unexpected situations or unexpected changes in routine? ___ Yes ___ No

   ___ Sometimes Explain: _____
   ask for, understand, and follow directions? ___ Yes ___ No ___ Sometimes

   Explain: _____
   safely and effectively travel through crowded and/or complex facilities? ___ Yes ___ No

   ___ Sometimes Explain: _____

7. If the person is speech impaired, is he or she able to:

   communicate verbally? ___ Yes ___ No ___ Sometimes

   Explain: _____

   communicate with an augmentative device? ___ Yes ___ No ___ Sometimes

   Explain: _____

   communicate in writing? ___ Yes ___ No ___ Sometimes

   Explain: _____

   communicate over the telephone? ___ Yes ___ No ___ Sometimes

   Explain: _____

I verify that the information provided on this Verification of Eligibility Form is true and correct to the best of my knowledge.

_____

Signature of Qualified Professional Date

_____ _____

Name of Qualified Professional (Print Please) License or Certification Number