



Access ADA Paratransit Service and Mobility Programs Application

Omnitrans offers a variety of transportation programs for seniors (62 plus) and individuals with disabilities who live in Omnitrans' service areas. See the brief descriptions of each program below and check the boxes next to the programs you would like to apply for.

Programs for Seniors and Individuals with Disabilities

- Travel Training - a professional trainer works one-on-one with individuals to teach them how to ride the Omnitrans bus system. Receive a free 31-day bus pass upon successful completion.

- Ride Program – choose one, Uber **OR** Taxi - receive a match once per month to use on either Uber or local taxi service.

Programs for Individuals with Disabilities

- Mileage Reimbursement - a monthly reimbursement for those who rely on others to drive them for transportation.

- Access ADA Paratransit Service - a curb to curb, shared-ride paratransit service for individuals with disabilities that prevent them from using the regular bus system all or some of the time.

HOW TO APPLY

Access ADA Paratransit Service

1. Complete Sections 1, 2, 3 and have a Healthcare Professional complete Section 4.
2. Call **(909) 379-7284** to schedule an in-person eligibility assessment at an Omnitrans facility.
3. **DO NOT** Mail, Fax or Email your application, bring it with you to your assessment.

Mileage Reimbursement, Ride, Travel Training

1. Complete Sections 1, 2, 3 and provide a copy of a photo ID, (California I.D. Card or Driver License).
2. If you have a disability, submit **one** of the proof documents listed on the following page.
3. Mail, Fax or Email your application, allow 21 business days to process.

Proof of Disability Documents (Submit One)

- Valid ADA or reduced fare ID card issued by Omnitrans or another transit agency
- Benefits or Award letter from Supplemental Social Security
- In-House Support Services (IHSS) benefits letter
- VA Letter of Disability or Disabled Veteran ID
- Medicare Card (if under age 62)
- DMV disability placard receipt
- Healthcare Professional Verification, Page 5 (required for Access applicants)

Additional Information Regarding the Access ADA In-Person Assessment and Eligibility

All Access ADA applicants are required to complete an in-person assessment with a Community Mobility Specialist at an Omnitrans facility by appointment only. You will need to bring your completed application packet, including the Healthcare Professional Verification Section completed by a qualified licensed medical professional. The review process may take up to two hours in addition to your travel time, and free transportation to and from your assessment is available upon request.

During the assessment, the Community Mobility Specialist will review your application and ask additional questions regarding your ability to use the regular bus system. You may be required to participate in a functional assessment outdoors in the community to further evaluate your abilities. You will receive your eligibility determination in writing within 21 days from the date your application is complete, which includes your in-person review and review of any additional information. You may be granted full eligibility (Unconditional), eligibility on a limited basis for specific conditions (Conditional), or for a temporary period (Temporary). Your photo will be taken during the in-person assessment and will be used on your ADA identification card if you are determined to be eligible.

Eligibility determinations are based solely on whether you have a disability which prevents you from riding the bus all or some of the time. Individuals who are determined to have the ability to ride the regular bus system for all trips will not receive eligibility for Access. If you disagree with your eligibility determination, you may select either a Level One or Level Two written appeal to Omnitrans within 60 days. In a Level One appeal, an Appeal Specialist independent of the Eligibility Department will review the documentation and any new information you provide which you feel is relevant. In a Level Two appeal, you can appear before an Appeal Review Panel to present information you feel should be taken into consideration. The panel's decision is final. For additional information regarding Omnitrans Access service, refer to the most recent version of the "Paratransit Policies for Persons with Disabilities" brochure.

Information that you provide will be used to determine eligibility for programs and is kept strictly confidential.

Section 1: APPLICANT INFORMATION

First Name _____ MI _____ Last Name _____

Home Address _____ City _____ Zip Code _____

Mailing Address _____ City _____ Zip Code _____

Home (____) _____ Cell (____) _____ Email _____

Birth Date (MM/DD/YY) ____/____/____ Age _____ Male Female

Emergency Contact Name _____ Phone Number (____) _____

Medicare/Medical ID # _____ Omnitrans Access ID # _____

Do you have a disability? Yes, permanent No Temporary, expected duration _____

Was your disability verified by a doctor? Yes, date verified _____ No

Is your disability military service-related? Yes, 30% or more Yes, less than 30% No

Section 2: CURRENT MOBILITY INFORMATION

Do you use any of the following? Walker (Can it be folded?) Yes No

Power Scooter Manual Wheelchair Electric Wheelchair Stroller-Type Chair

Oxygen Prosthetics Crutches Braces Cane/White Cane

Certified Service Animal Other _____

Do you have any special communication needs (large print, Braille, TDD/California Relay, etc.)?

Do you currently ride the regular bus system? Yes No Sometimes

If not, how do you currently travel? _____

What is or would be the most difficult part of riding the bus for you?

Are you or would you be able to get to the bus stop and board the bus without someone else's assistance? _____

Do you know which bus routes serve your neighborhood and are closest to your home?

How would you describe the area where you live (steep hill, gradual hill, etc.)?

Do you live on the ground floor? Yes No

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

Are there sidewalks at your residence? Yes No

Is there a ramp at your residence? Yes No

How did you hear about our programs?

Outreach Event/ Resource

Social Worker/Case Manager

Family/Friends

Bus book

Online

Other: _____

Section 3: APPLICANT AGREEMENT

If Applying for Omnitrans Access ADA:

I have read and fully understand the eligibility process as described in the Omnitrans Access Paratransit Eligibility Guide included with this application. 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 have read and fully understand the conditions for service outlined in the Omnitrans Access Paratransit Policies and agree to abide by them.

If Applying for Mileage Reimbursement Program, Taxi Ride Program, or Uber Ride Program:

I acknowledge that being driven by others is an inherently dangerous activity and that participation in these programs could involve some danger to my person or property, or the person or property of others. In consideration of my participation in the Mileage Reimbursement and/or Ride programs, I agree to indemnify and hold harmless Omnitrans, its officers, directors, agents, employees, and volunteers, as well as any and all organizations, agencies, or individuals who provide funding to or otherwise support the programs, from any and all claims, losses, and liabilities (including costs and attorney’s fees) for damage due to property or injury or death to myself or others arising out of or in any way connected to my participation in the Mileage Reimbursement and/or Ride programs.

For All Applicants:

I understand and agree to indemnify and hold harmless Omnitrans against all claims or liability for damages to any person, property, or personal injury 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 certify that the information provided in this application is true and correct. I understand that the information I am providing will be treated as confidential, will only be utilized to determine my initial and continuing eligibility for the programs, and will be retained as a permanent part of my file. 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 and/or other programs operated by Omnitrans Mobility Services.

I agree to abide by all Omnitrans policies, as communicated to me, including policies in program guidelines, and I acknowledge that my failure to abide by any program policy may result in the termination of services. I understand that it is the policy of Omnitrans to pursue any alleged or suspected instances of fraud. A “fraudulent claim” is committed when a false representation of a present or past fact is made by an Omnitrans consumer, member of his/her family, or unrelated person such as their caregiver or volunteer driver, which results in the release of funds. I understand that Omnitrans Special Transportation Services may at times revise the policies and forms used for programs, and I agree to abide by the most recent versions of all documents.

Applicant Signature _____ **Date** _____

Name of person who helped fill out the application for the applicant.

Name _____ Phone (____) _____
Signature _____ Date _____

Section 4: Healthcare Professional Verification - Required for All Omnitrans Access ADA Applicants

This verification form must be completed by a qualified licensed healthcare professional. Examples include but are not limited to a physician, psychiatrist, psychologist, chiropractor, ophthalmologist, registered nurse, or social worker.

Name of Professional _____ License No. _____
Title _____ Agency/Affiliation _____
Business Address _____
Business Telephone (_____) _____

Name of client: _____

Medical diagnosis that causes the client's disability _____

Is the condition temporary? Yes (Expected duration: _____) No, it's permanent

Does the applicant's disability require they travel with an attendant? Yes No Sometimes

Explain "Yes" or "Sometimes" _____

Complete if client has a visual impairment

Best corrected acuity? Right _____ Left _____ Field restriction? Right _____ Left _____

If the client has a disability affecting mobility or is legally blind, are they able to:

- Travel a distance of 200 feet without assistance? Yes No Sometimes
- Travel a distance of 3 blocks (1/4 mile) without assistance over different types of terrain? Yes No Sometimes
- Travel a distance of 6 blocks (1/2 mile) without assistance over different types of terrain? Yes No Sometimes
- Wait outside without support for 15-30 minutes in different weather conditions? Yes No Sometimes
- Cross a 2-way stop? Yes No Sometimes
- Cross a 4-way stop? Yes No Sometimes
- Cross traffic light-controlled intersections in a residential, semi-business, or business area? Yes No Sometimes

Explain "No" or "Sometimes" responses: _____

If the client has a cognitive disability, are they able to:

- Give their name, address, and telephone numbers upon request? Yes No Sometimes
- Recognize a destination or landmark? Yes No Sometimes
- Deal with unexpected situations or unexpected changes in routine? Yes No Sometimes
- Ask for, understand, and follow directions? Yes No Sometimes
- Safely and effectively travel through crowded and/or complex facilities? Yes No Sometimes

Explain "No" or "Sometimes" responses: _____

If the client is speech impaired, are they able to:

- Communicate verbally? Yes No Sometimes
- Communicate with an augmentative device? Yes No Sometimes
- Communicate in writing? Yes No Sometimes
- Communicate over the phone? Yes No Sometimes

Explain "No" or "Sometimes" responses: _____

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 Healthcare Professional _____ Date _____