Application for ADA Complementary Paratransit Service

Dear Handi-Ride Applicant:

Attached is the application form for you to use to apply for eligibility for Handi-Ride, which is the "ADA Complementary Paratransit" service of Hampton Roads Transit (HRT). Under the Americans with Disabilities Act of 1990 (ADA), this service is provided for those persons who, because of their disability(ies), cannot use the regular fixed-route public bus service for some or all of their transit trips. Handi-Ride service is restricted to eligible individuals and is subject to "service criteria" outlined in federal regulations.

Please be sure to fill in all four (4) of the following pages completely and sign the application. **If your application form is not complete, we will return it to you.**

We will contact you after we receive your application form to schedule an in-person interview and functional assessment to determine your eligibility for ADA complementary paratransit service. This is a required part of the application process, and your application is not considered complete until you have the in-person interview at one of the HRT offices. In some cases, we may need to contact a licensed or certified professional familiar with your disability (ies) to verify additional information.

ADA complementary paratransit service is a civil right for people who are eligible, but it is very expensive to provide. We encourage you to use the HRT bus whenever you can. Reduced fares are available for many people with disabilities and for seniors over age 60. In addition, "travel training," to help you learn how to better use the bus, may be available to you. Contact us for more information about this training.

If you have any questions regarding this form, the paratransit eligibility process, or other HRT services for seniors and people with disabilities please contact:

ADA Information - Telephone 757-222-6087

Mail your completed application form to:
Hampton Roads Transit
Attention: Handi-Ride Certification
3400 Victoria Boulevard
Hampton, VA 23661

CERTIFICATIONS AND AUTHORIZATION TO RELEASE RECORDS

By my signature below, the following licensed or certified professionals are hereby authorized to release to Hampton Roads Transit any necessary information about my disability (or that of my child or the person for whom I am legal guardian, as appropriate), including medical information and records, in order to verify eligibility for ADA complementary paratransit services.

The individual(s) listed below cannot be the individual assisting in the completion of this application.

Please identify below the ***medical professional*** most knowledgeable about your functional abilities; for example, your personal physician or psychiatrist.

Name of Medical Professional: _____
Phone: _____ Fax: _____
Address: _____
City: _____ State: _____ Zip: _____
What is this person's professional field or expertise? _____

Please identify below ***another professional*** who understands your functional ability to use fixed route service; for example, a physical therapist, occupational therapist, rehabilitation specialist, clinical social worker, etc. Please do not identify a friend or family member.

Name of Professional: _____
Phone: _____ Fax: _____
Address: _____
City: _____ State: _____ Zip: _____
What is this person's professional field or expertise? _____

- I understand that it may be necessary to contact a professional familiar with my functional abilities to use public transit (or those of my child, or _____, as appropriate) in order to assist in the determination of eligibility.
- I understand that the medical and other information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and/or past medical history.
- I understand that any information contained in or obtained from this application may not be protected by federal confidentiality rules but will be used solely for the purpose of my request for transportation service.
- I understand this authorization will expire, without my express revocation, one year from the date of signing, or if the applicant is a minor, on the date they become an adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization.

Applicant (or parent/legal guardian) Signature _____ Date_____
Print Applicant Name: _____

Hampton Roads Transit Application for ADA Complementary Paratransit Service

Name: Last _____Initial_____ First_____Suffix____

Home Address: _____Apt. #:_____

City: _____State: _____ Zip: _____

Mailing Address (if different): _____ Apt.#: _____

City: _____State: _____ Zip: _____

Daytime Phone: _____ - _____ - _____ TDD/TTY: _____ - _____ - _____

Evening Phone: _____ - _____ - _____ Mobile Phone: _____ - _____ - _____

E-mail: _____

Birth Date: _____-_____-_____ Gender: ☐ Female ☐ Male

Do you need this application and future written information provided to you in an accessible format? ☐ Yes ☐ No

If yes, check which format(s) you can use, and circle the one you prefer:

☐ Audio Tape ☐ Braille ☐ Diskette ☐ CD-Rom

☐ Large Print ☐ E-mail: ☐ Other (specify) _____

Do you need a sign interpreter or other assistance for your eligibility interview?

☐ Yes ☐ No

If yes, explain: _____

Are you currently eligible for Medicaid transportation? ☐ Yes ☐ No

If a person other than applicant helped to fill out this form, please identify:

Name: _____ Phone: _____ - _____ - _____

Address: _____ City: _____ Zip: _____

Relationship to applicant: _____

Please identify a person we can notify in case of an emergency, if needed:

Name: _____ Day Phone: _____ - _____ - _____

Relationship: _____ Eve. Phone: _____ - _____ - _____

Please answer the following questions in detail. (Use extra paper if needed.)

1. What is/are your disability (ies)?

_____

_____

2. How does your disability (ies) prevent you from independently using the public fixed route transit system?

_____

_____

3. Are the condition(s) you described ☐ permanent or ☐ temporary? (Please check one.)

If temporary, the condition(s) are expected to continue until _____?

4. How do you currently travel within the Hampton Roads area? Check all that apply and identify how often you use each in an average week:

☐ Someone drives me	_____ round trips per week
☐ Drive myself	_____ round trips per week
☐ HRT bus	_____ round trips per week
☐ School bus	_____ round trips per week
☐ Handi-Ride	_____ round trips per week
☐ Taxi	_____ round trips per week
☐ Social service agency vehicle	_____ round trips per week
☐ Other: _____	_____ round trips per week

5. Does your disability change from day to day in a way that affects your ability to use public fixed route transit?

☐ Yes, good on some days, bad on others ☐ No, same all the time ☐ Don't know

If you checked "yes" or "don't know," please explain:

_____

6. Do you know the location of the bus stop nearest your residence?

☐ No (Go to Question 7) ☐ Yes, Location: _____

How far is the stop from your residence? _____

☐ On your block ☐ 1 block ☐ 2 blocks ☐ 3 blocks ☐ 4 blocks

Going to, from and/or at the stop you listed above, are there any specific conditions or barriers that prevent you from using the bus? (Please be as specific as possible)

☐ No ☐ Yes, if yes, please explain: _____

7. Do you use any of the following mobility aids or specialized equipment? Check all that apply and circle the one you use most frequently:

☐ Cane	☐ Crutches	☐ Wheelchair/Scooter
☐ Walker	☐ Communication Board	☐ White Cane
☐ Service Animal	☐ None	☐ Other: _____

8. Do you need the assistance of a personal care attendant (someone provided by you) to accompany you when you travel outside your home (e.g., to push your wheelchair, carry oxygen, assist with tasks, etc.)?

☐ Yes, always ☐ No ☐ Sometimes (please explain_____

- I certify that the information in this application is true and correct to the best of my knowledge.
- I understand that any falsification of the information I provide in this application may result in denial of service and possible criminal sanctions.
- I understand that I must notify the Hampton Roads Transit paratransit office of any changes in disability or travel that affect my ability to use public transit.

Applicant (or parent/legal guardian) Signature_____ Date_____
Print Applicant Name: _____

PLEASE NOTE
In compliance with the Americans with Disability Act of 1990 (ADA), Hampton Roads Transit (HRT) here informs you that within twenty-one days of "receiving a complete application, including professional verification if needed," a decision concerning your eligibility will be made. You will then be notified of the determination by mail. If a decision is not made by the twenty-first day after your interview, you will become "presumptively eligible". This status grants you the right to use the Handi-Ride service until the actual determination of your paratransit eligibility. You will be notified by telephone that you are "presumptively eligible". This status remains in effect until you receive written notification of your eligibility determination.
Please review your application. **If it is not filled out completely, it will be returned to you for completion. Send completed application to:** Hampton Roads Transit, Attention: Handi-Ride Certification, 3400 Victoria Blvd., Hampton, Virginia 23661.

PLEASE USE THIS PAGE FOR ADDITIONAL COMMENTS