Southeast Vermont Transit (SEVT)

Application for Complementary
Paratransit Service

ADA Paratransit Eligibility Application and Instructions

Dear Applicant,

Thank you for inquiring about applying for Southeast Vermont Transit's ADA Paratransit Eligibility. Enclosed is a copy of an application for Certification of ADA Paratransit Eligibility.

Please read the enclosed materials carefully before completing the application.

ADA Paratransit service at Southeast Vermont Transit provides service to individuals who are unable to use the fixed-route bus service because of a disability. An inability to use fixed route bus service may include being unable to travel to and from bus stops, board or exit busses, or understand how to ride and use the bus system.

Currently, SEVT is required to provide ADA complementary paratransit service on all our in-town fixed routes. We do not provide ADA complementary paratransit on our commuter routes.

SEVT Paratransit provides shared ride, door to door service to persons determined to be "ADA Eligible" for those trips that cannot be made using the fixed route service. You may, for example, be able to use fixed route service for some trips if stops are nearby and there are no barriers that prevent you from getting to and from the bus. At other times, you may not be able to use the bus, SEVT's paratransit service is meant to assist you at those times.

To enable us to accurately determine your eligibility for this service, please complete the enclosed application as accurately as possible. The questions are meant to determine the circumstances under which you can use fixed route or ADA paratransit services.

If you need assistance completing this form, or have questions, please contact our office at 802-460-7433 (voice) or TTY 711. This letter and application are available in alternate formats.

After you have completed the application information, please have a licensed health care professional or disability case worker who is familiar with your health condition or disability and your functional abilities, limitations complete the health care professional information. The information you provide in this application is confidential. Please do not attach medical information to this application.

Please mail your application to: The Rockingham MOOver, 706 Rockingham Road, Rockingham, Vermont 05101.

Completed applications will be processed within twenty-one days of receipt. You will then be notified in writing of your eligibility status. If additional time is required to complete the evaluation and determination you will be given temporary eligibility until the process is completed.

If we determine that you are able to use SEVT's fixed route service, and therefore in-eligible for ADA paratransit service, we will notify you of the reason(s) for this determination. You may appeal this decision in writing. SEVT will not provide ADA complementary paratransit service during the appeal process, unless the appeal process cannot be concluded within thirty days.

Attached with this packet for additional information is our ADA Paratransit Service Guidelines and Routes.

Sincerely,

Christine Howe General
Manager
The Rockingham MOOver

Applicant Information

Title: Mr. Mrs. Miss. Ms. Name: _____

Mailing Address: _____

_____

Physical Address (if different from mailing): _____

_____

Phone Number (day): _____ (evening): _____

Date of Birth: _____/_____/ _____ Gender: [ ] Male [ ] Female

Primary Language: [ ] English [ ] Spanish [ ] Sign
[ ] Other: _____

Accessible Formats: [ ] Standard Print [ ] Large Print [ ] Braille [ ] Audio Tape
[ ] Other: _____

Type or Eligibility: [ ] Conditional Temporary [ ] Conditional Permanent
[ ] Unconditional Temporary [ ] Unconditional Permanent

Please give us the name and phone number of a friend or relative we can call in case we are unable to reach you at your regular number:

Name:_____Relationship: _____

Telephone/TDD (Day):_____(Evening): _____

If this application has been completed by someone other than the applicant requesting certification, that person must complete the following:

Name: _____

Address: _____

Telephone: (day)_____(evening) _____

Signed:_____Date: _____

In case of emergency: please list names of two people, including support professionals, agencies or other familiar with your disability that SEVT can contact:

Name:_____Relationship: _____

Business/Work#_____Home#_____

Address: _____

_____

Name: _____ Relationship: _____

Business/Work# _____Home#_____

Address: _____

_____

Name: _____ Relationship: _____

Business/Work# _____Home#_____

Address: _____

_____

About Your Disability

1. Do you have a disability, which prevents you from using the Southeast Vermont Transit's fixed-route bus service? [ ] Yes [ ] No

If yes, please describe any and all physical, mental, visual, or functional disabilities which prevent you from using Southeast Vermont Transit's fixed-route bus services.

_____

_____

_____

_____

_____

_____

2. Explain how your disability prevents you from independently using fixed-route bus service:

_____

_____

_____

_____

_____

_____

3. Are the conditions you described? [ ] Permanent [ ] Temporary [ ] Vary Day to Day

If temporary, how long do you expect to have this disability?

_____

_____

_____

4. Do you have medically defined cold sensitivity? [ ] Yes [ ] No

Above or below what temperatures?

_____

If yes, please explain:

_____

_____

_____

5. Do you have medically defined heat sensitivity? [ ] Yes [ ] No

Above or Below what temperatures?

_____

If yes, please explain:

_____

_____

_____

6. Do other weather/lighting conditions (wind, dusk/dark and or glare) affect your disability?

If yes, please explain:

_____

_____

_____

7. Do you have a visual impairment? [ ] Yes [ ] No [ ] Sometimes

If yes or sometimes, please explain:

_____

_____

8. Is your breathing affected by weather or environmental conditions?

[ ] Yes [ ] No [ ] Sometimes

If yes or sometimes, please explain:

_____

_____

_____

9. Does the extent of your disability change after medical treatment?

[ ] Yes [ ] No [ ] Sometimes

If yes or sometimes, please explain:

_____

_____

_____

10. Are there any other comments or additional information relating to your disability that you would like to explain?

_____

_____

_____

_____

_____

_____

_____

Traveling To and From Bus Stops

1. Are you able to locate fixed-route bus stops, destinations, locations, or cross streets independently? [ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:

_____

_____

2. Are you able to travel independently after dark? [ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:

_____

_____

3. Are you able to safely and independently travel 200 feet without help from another person? [ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:

_____

_____

4. Are you able to safely and independently travel 1/4 mile (about 4 blocks) without help from another person? [ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:

_____

_____

5. Are you able to reach and return from your neighborhood bus stop independently? [ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:

_____

_____

6. Are you able to wait outside without assistance or support for 10 (ten) minutes?
[ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:

_____

_____

7. Are you able to leave and return to your regular destination (local bus stops) independently? [ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:

_____

_____

8. Are you able to wait longer than 15 minutes? [ ] Yes [ ] No [ ] Sometimes

If so, how long can you wait?_____minutes

9. Are you able to travel on flat surfaces in good weather?
[ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:

_____

_____

10. Are you able to travel on slight inclines in good weather?
[ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:

_____

_____

11. Are you able to get to and from the nearest public transit stop?

[ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:

_____

_____

12. Could you wait if there were a seat or a bus shelter?

[ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:

_____

_____

_____

13. Could you wait if there were **NO** seat or bus shelter?

[ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:

_____

_____

_____

14. How long are you able to wait for a bus to arrive? _____minutes

Boarding and Alighting the Bus

1. Can you safely and independently walk up and down three (3) 12-inch steps?
   [ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:

_____

_____

2. Are you able to board, ride, or exit a wheelchair accessible bus without assistance?
   [ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:

_____

_____

3. Are you able to grasp handles or railings while boarding or exiting a bus?
   [ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:

_____

_____

4. Are you able to board or exit a vehicle if it has a kneeler that lowers the front of the bus?
   [ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:

_____

_____

5. Are you able to get on and off a bus without assistance?
   [ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:

_____

_____

_____

6. Have you ever had training to learn how to travel around the community or on how to use the fixed-route buses? [ ] Yes [ ] No

7. Would you like information about free training to use the fixed-route buses?
[ ] Yes [ ] No

8. List the three places you go most often and how you get there now.

a. Where do you go?

_____

Address? _____

How often do you go there? _____

How do you get there now? _____

b. Where do you go?

_____

Address? _____

How often do you go there? _____

How do you get there now? _____

c. Where do you go?

_____

Address? _____

How often do you go there? _____

How do you get there now? _____

d. Where do you go?

_____

Address? _____

How often do you go there? _____

How do you get there now? _____

Service Delivery

1. Do you use a wheelchair or scooter? [ ] Yes [ ] No

   How wide is it?_____inches.

   How heavy is it when occupied?_____pounds.

This information is not used to determine paratransit eligibility. It is the applicant's responsibility to know the dimensions of their mobility device and whether it exceeds the definition of a common wheelchair.

The Americans with Disabilities Act of 1990
Defines a Mobility Device as no more than 30 inches wide, 48 inches long, when measured 2 inches above the ground and weighing no more than 800 pounds when occupied. If your mobility device exceeds these dimensions, the ADA does not guarantee paratransit service.

2. Do you use any of the following mobility aids or specialized equipment when traveling? Check all that apply.

[ ] Manual Wheelchair [ ] Long White Cane [ ] Cane [ ] Crutches

[ ] Communication Board [ ] Power Wheelchair [ ] Service Animal [ ] Walker

[ ] Power Scooter (3 Wheeled) [ ] Large Power Chair (exceeds ADA)

[ ] Other Aid: _____

3. If you use a wheelchair or scooter, will you use it on paratransit?
   [ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:

_____

_____

_____

4. Are you able to wait 15 minutes at a public bus stop with your mobility device?
[ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:

_____

_____

_____

5. Do you require an attendant (personal care, sight guide) to travel with you? An attendant may assist you with any personal or travel needs, such as crossing the street, navigating stairs, etc.
[ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:

_____

_____

_____

6. Do you travel with children under the age of 10? [ ] Yes [ ] No

Release of Information

I, the applicant, understand that the purpose of this application is to determine my eligibility to use SEVT's ADA Paratransit service. I hereby authorize my health care professional to release information about my disability and its effect on my ability to travel, which may be needed in connection with my request for ADA paratransit eligibility certification. It is my understanding that the information released will be used solely to determine my ADA paratransit eligibility.
I agree to release this information to SEVT. This release authorizes SEVT to directly contact my health care professional for further information or clarification of the information provided.

I agree to notify Southeast Vermont Transit. of any changes in the status of my disability that affects my ability to use ADA complementary paratransit service. I understand that providing false information in this application could result in a loss of ADA paratransit service as well as a penalty under the law.

I hereby certify that I am the individual requesting certification for ADA complementary paratransit service and that all information contained in this application is true and accurate:

_____

Printed Name of Applicant

_____

Signature **Date**

If the applicant is a minor or has a legal guardian, the parent or guardian must sign this application and attest to the accuracy of the information contained herein.

_____

Signature of Parent or Legal Guardian **Date**

FOR INTERNAL USE ONLY

Application reviewed for completeness
By: _____

Date completed application received: _____
Application tracking number: _____

Southeast Vermont Transit (SEVT)

Attachment to Application for ADA Complementary Paratransit Service

Dear Health Care Professional or Disability Case Worker

Federal law requires that Southeast Vermont Transit (SEVT) provide complementary paratransit service to persons who cannot use the accessible fixed route bus system.

The information you provide in the attached Professional Verification will allow SEVT to make an appropriate evaluation of the applicant's mobility and determine how we may best meet their needs.

In accordance with the "Americans with Disabilities Act of 1990" (ADA) and its regulations, Section 37.123 (e), there are two specific circumstances under which a person would be considered ADA eligible for SEVT's Complementary Paratransit Service.

1. Any individual with a disability who is unable, as a result of a physical or mental impairment (including a vision impairment), and without the assistance of another individual (except the operator of a wheelchair lift or other boarding assistance device), to board, ride, or disembark from any vehicle on the system which is readily accessible to and usable by individuals with disabilities.

2. Any individual with a disability who has a specific impairment-related condition which prevents such individual from traveling to a boarding location or from a disembarking location on such system.

Please Note:
This does not include persons who find it uncomfortable or difficult to get to and from bus stops.

Resources for this service are limited, and your evaluation of each person must be based solely upon the individual's ability to use regular transit service. All fixed route buses are ADA accessible. Your verification should consider only the presence of a disabling condition, not the applicants' economic status. Please exercise care in evaluating applicants for this service.

If you have any questions about the application or the review process,
please contact The Rockingham MOOver at (802) 460-7433

Sincerely,

Christine Howe
General Manager

Health Care Professional

This part of the application form should be completed by one of the following health care professionals who is currently treating the applicant for their disability, and is authorized to provide this information to The Rockingham MOOver (SEVT) in order to complete the application for certification:

Check The Appropriate Box To Identify Your Profession

[ ] A Rehabilitation Specialist

[ ] An Orientation and Mobility Specialist

[ ] An Occupational or Physical therapist

[ ] An Independent living counselor

[ ] A Social worker

[ ] A vocational rehabilitation counselor

[ ] An ophthalmologist or optometrist

[ ] A physician or registered nurse

[ ] A psychologist or psychiatrist

[ ] A mental health counselor

Applicant Name: _____

1. In what capacity do you know the applicant and for how long?

_____

_____

2. Is the applicant your regular client? [ ] Yes [ ] No

3. Please indicate all the medical diagnoses of the applicant's disability. (Please print clearly.)

_____

_____

4. Is the condition temporary? [ ] Yes [ ] No

If yes, please specify the time from (example: 6 months) within which you anticipate the applicant to recover or next reevaluation.

_____

_____

5. Is this condition likely to worsen? [ ] Yes [ ] No

6. Does the applicant require use of the following? (Check All, Where It Applies)

	Yes	No	Sometimes
Manual wheelchair	_____	_____	_____
Motorized wheelchair	_____	_____	_____
Cane, Crutches, or Walker	_____	_____	_____
Service animal	_____	_____	_____
Personal care attendant	_____	_____	_____

7. Is the applicant able to do any of the following with the use of a mobility aid and without the assistance of another person?

	Yes	No	Sometimes
Travel ½ Block?	_____	_____	_____
Travel 1 Block?	_____	_____	_____
Travel 2 Blocks?	_____	_____	_____
Travel 4 Blocks or More:	_____	_____	_____
Climb Three 12” Steps?	_	_____	_____
Wait outside without support for 10 minutes?	_____	_____	_____

If “No” or “Sometimes”, describe in detail any factors which would have an adverse impact on the applicants abilities to travel or wait outside.

_____

_____

8. Can the applicant independently cross the street? [ ] Yes [ ] No

9. Under what circumstances do you believe the applicant could independently use accessible SEVT fixed route bus service? Please describe. (example: if person receives transit orientation, if distance to bus stop is not too great)

_____

_____

10. Is the applicant able to:

Give addresses and phone number upon request?	[ ] Yes	[ ] No
Recognize a destination or landmark?	[ ] Yes	[ ] No
Sign his/her name?	[ ] Yes	[ ] No
Deal with unexpected situations?	[ ] Yes	[ ] No
Ask for, understand, and follow directions?	[ ] Yes	[ ] No

11. Is the applicant currently taking any medication that would likely have an impact in their travel abilities or limitations? [ ] Yes [ ] No

If yes, please list if there are any side effects?

_____

_____

12. Does the applicant experience episodic days? [ ] Yes [ ] No

13. Is the disability the same every day? [ ] Yes [ ] No

14. Does weather impact the applicant's ability to travel? [ ] Yes [ ] No

If yes, please explain and list the temperatures at which the applicant would be impacted.

_____

I hereby affirm that the statements made herein are true and correct.

Signature:_____ **Date:** _____
Professional's Signature

Name: _____
Professional's Name Printed

Office Address: _____

City:_____ **State:**_____ **Zip Code:** _____

Office phone:_____ **Office Fax:** _____

Please return this completed form directly to your patient