



APPLICATION FOR ADA PARATRANSIT SERVICES ELIGIBILITY

Applicant,

Thank you for inquiring about eligibility for Citibus Access ADA Paratransit Service. Access is for individuals with a disability or disabling health condition that prevents them from independently using the accessible Citibus fixed route service either all of the time, temporarily or under certain circumstances. The Americans with Disabilities Act (ADA) outlines specific criteria to determine eligibility for paratransit services; therefore, an application and in-person eligibility review are required to determine an applicant's individual eligibility.

The following application must be filled out legibly and completely. The physicians form must be completed by a doctor, licensed health care provider, or licensed social caregiver familiar with your disability. After Access receives your completed application you may be contacted to schedule an in-person interview to determine your eligibility. Transportation will be provided to you free of charge both to and from the in person interview/assessment.

You will receive your eligibility determination within 21 business days from the date that your interview and functional assessment have been completed. If you require any assistance in completing this application you may call our scheduling office at 806-775-3640.

Again, we thank you for your interest in Citibus Access.

Citibus Operations
806-775-3640





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Return completed application to:

CITIBUS
Attn: Citibus Access Eligibility
801 Texas Avenue
Lubbock, Texas 79401

Or by fax: 806.775.2955

OFFICE USE ONLY

Determination:

Expiration Date:

Assessment Date:

Date Letter Mailed:

To ensure your application is processed in a timely manner, all questions must be answered. Part A and Part B must be submitted at the same time. Incomplete applications will be returned to applicant and/or individual/agency completing application. All information is kept confidential. Citibus Access will only use the information obtained in this certification process for the provision of transportation services.

PART A: General information regarding applicant

To be completed by applicant or on behalf of applicant. *(Please Print or Type)*

☐ New Applicant

☐ Recertification

Last Name

First Name

Mid. Initial

Date of Birth

☐ Male ☐ Female

Street Address

Apt/Suite #

Name of Apt Complex/Nursing Home

City

State

Zip

Mailing Address if Different

Home Phone

Cell Phone

E-Mail



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Please answer all of the following questions.

1. What is your physical, mental, or other disability which limits your ability to travel? (Please identify most limiting conditions.)

2. Is this condition temporary? ☐ No ☐ Yes If yes, for how long? _____

3. Please explain as completely as possible how your disability prevents you from getting on (boarding), riding, or getting off (de-boarding) a fixed route bus or how it prevents you from getting to the bus stop.

4. My condition: (mark all that apply) ☐ Is constant ☐ Changes daily
☐ Changes at different times of the day ☐ Is in remission ☐ Not applicable

5. I use the following to assist me (mark all that apply).

- | | | |
|-------------------------------------|--|--|
| <input type="checkbox"/> Cane | <input type="checkbox"/> Crutches | <input type="checkbox"/> Portable oxygen or respirator |
| <input type="checkbox"/> White Cane | <input type="checkbox"/> Manual wheelchair | <input type="checkbox"/> Personal Care Attendant |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Motorized wheelchair or scooter | <input type="checkbox"/> Communication Device |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Wheelchair 24 to 34 inches wide | |

- ☐ Other answer: _____

If you marked wheelchair or scooter does the combined weight of the mobility device and your weight exceed 600 lbs? ☐ No ☐ Yes

Do you use a service animal? ☐ No ☐ Sometimes ☐ Yes

If yes or sometimes, please describe the type of animal and what service(s) the animal is trained to perform: _____



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6. Do you currently use the Citibus fixed route service?

- ☐ Yes Which routes? _____
- ☐ No, because
- ☐ I have never tried.
 - ☐ I have difficulty getting on or off the bus.
 - ☐ I have difficulty riding specific routes. Why? _____
 - ☐ I have difficulty traveling to and from the bus stops.
 - ☐ I have difficulty recognizing the bus stops.
 - ☐ Other (specify) _____

7. Are you prevented from traveling to or from a bus stop boarding location for one or more of the following reasons?

- ☐ Inability to negotiate terrain in the area (no sidewalks, hills, etc.) Please explain _____
- _____
- ☐ Extreme sensitivity to climatic conditions. Please explain _____
- _____
- ☐ Environmental sensitivities. Please explain _____
- ☐ Hyper-fatigue, frailty
- ☐ Bus stop too far away
- ☐ Other reasons. Please explain: _____

8. Are you **able** to perform the following functions?

- | | |
|---|---|
| <input type="checkbox"/> Get to a bus stop | <input type="checkbox"/> Ask for and follow written or oral directions |
| <input type="checkbox"/> Cross the street at traffic lights | <input type="checkbox"/> Find your way between familiar locations |
| <input type="checkbox"/> Cross the street at busy intersections | <input type="checkbox"/> Travel alone from drop off point to destination |
| <input type="checkbox"/> Navigate the Citibus fixed routes | <input type="checkbox"/> Recognize your destination or landmark near your destination |
| <input type="checkbox"/> Board and get off of a fixed route bus | |
| <input type="checkbox"/> Transfer from one fixed route to another | |

If you are unable to do any of the above please explain what prevents you.



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9. List three of your most frequent destinations, and how you get there? Please be specific.

Destination & Street Address	Frequency of Travel	How do you get there now?
Ex. Walmart, 702 W. Loop 289	Twice a week	Route 9 or Friend or family member

10. Are there places you would like to go that you *cannot* get to now?

Destination & Street Address	Frequency of Travel	How do you get there now?
Ex. Covenant Southwest, 9812 Slide Rd	Once a month	Cab

In Case Of Emergency Notify (Please select someone who would NOT be riding with you):

Name Relationship

Home Phone Work Phone

Address City State Zip Code



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Please read and initial that you understand the following Access policies.

1. Eligibility is based on how my disability impacts my functional ability to use the accessible Citibus fixed route service. _____
2. I will be asked to complete a physical/functional assessment, and I will need to bring all mobility aids (including service animals) that I typically use in the community. _____
3. Access is public transportation and I will be sharing rides with other passengers. _____
4. Access does not provide emergency service. _____
5. Excessive no shows could result in ridership suspension per the Guide to Ride. _____
6. Access has 15 minutes before and 15 minutes after the scheduled pick up time to arrive. _____
7. Access will wait only 5 minutes from the time it arrives. _____
8. Access is a curb to curb service. _____

I understand that this application is part of the process to determine eligibility for ADA paratransit service. I certify that the information provided in this application is accurate. I understand that false information may result in the denial or annulment of Access service. I further understand that all information will be kept confidential, and only the information required to provide the services I request will be disclosed to those who perform those services.

Applicant's Signature _____ Date _____

Interviewer's Signature _____ Date _____

****If applicant has been assisted by someone else in completing this application, that person must complete the following:**

Last Name First Name Mid. Initial

Street Address Apt. No.

City State Zip Code

Home Phone Work Phone Relation to Applicant



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ACCESS SERVICES ASSESSMENT INFORMED CONSENT & HEALTH INFORMATION

I understand that part of the functional assessment occurs indoors and outdoors.

I may be asked to perform several activities:

- Physical tasks such as walking or using mobility aid to travel several city blocks or a distance equal to the average street length within a specific time, going up and down curbs and/or curb cuts, and getting on and off a simulated public transit bus.
- Cognitive tasks such as recognizing bus route numbers, finding the way to a specific place and obtaining public transit information.
- Obtaining a weight and measurement of me with my mobility aid.
- Having a digital photo taken (for the purpose of providing Access services only).

I understand that private health information from the evaluations will be kept confidential. It will be reviewed by Citibus staff and those performing the evaluations and used to help determine my eligibility for Citibus Access Services. I have read this form and I understand the evaluation procedures and agree to assume the risks and take responsibility for injury or property damage suffered by me during the evaluations not caused by negligence on the part of Citibus Access.

Signature of Applicant (Guardian if Applicable)

Date



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PART B: HEALTH CARE PROVIDER ASSESSMENT AND VERIFICATION

Dear Health Care Professional:

In order to complete this application on behalf of the applicant, you must be either a certified or license professional.

The applicant is asking you to complete and sign Part B of this form certifying that they have a disability that prevents them from using fixed route bus service (regular city buses). This information will be used to help determine whether or not the applicant needs to use paratransit (curb-to-curb) service or is able to use fixed route service for all or some of their travels. **Please make sure to include any supporting documentation that you feel will assist us in making an eligibility determination.**

Under the Americans with Disabilities Act (ADA), if a person has the functional and cognitive ability to use Citibus Fixed Route buses, that person is not eligible for paratransit services. Disability alone, distance to and from a bus stop, or the availability of fixed route bus service, is not by itself, a qualifier for paratransit services. Eligibility for other programs is also not a qualifier.

All Citibus fixed route buses are ramp equipped for use by individuals using wheelchairs or by individuals who are not able to use steps

Please note: If you do not have Part A, you will need to return Part B to the applicant. We must receive both part A and Part B as one submission.

Who can complete Part B: [must be licensed/certified]

Vocational Rehabilitation
Social Worker
Respiratory Therapist
Psychologist
Psychiatrist
Audiologist
Independent Living Specialist

Certified Orientation & Mobility Specialist
Physician
Physician Assistant
Nurse Practitioner
Physical Therapist
Optometrist / Ophthalmologist
Registered Nurse



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To Be Completed and signed by appropriate health care provider (please print or type)

I am a licensed: (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Medical Doctor (MD or DO) | <input type="checkbox"/> Physician's Assistant |
| <input type="checkbox"/> Psychologist (Ph. D.) | <input type="checkbox"/> Optometrist or Ophthalmologist |
| <input type="checkbox"/> Psychiatrist (MD or DO) | <input type="checkbox"/> Physical or Occupational Therapist |
| <input type="checkbox"/> Licensed Mental Health Professional | <input type="checkbox"/> Certified Orientation & Mobility Specialist |
| <input type="checkbox"/> MDS Nurse (Skilled Nursing Facilities) | <input type="checkbox"/> Licensed Rehab/Social Worker |
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Other _____ |

Applicant's Name _____
Last First Mid. Initial

The applicant has been diagnosed with the following disability(ies) a ☐ Physical ☐ Cognitive *
☐ Behavioral/Psychiatric* ☐ Seizures Disorders* ☐ Vision* ☐ Other _____

* see appropriate section below

Medical diagnosis of condition causing disability: _____

Is the condition permanent? ☐ Yes ☐ No If not, expected duration: _____

Does this disability prevent the applicant from utilizing the fixed route services (regular bus service)? If yes, please describe in detail. _____

Is the applicant currently on medication(s) that have side effects that will significantly reduce or hinder their ability to independently ride the fixed route buses? ☐ No ☐ Yes

If you selected yes, please explain how the side effects would hinder this applicant's ability to use the accessible fixed route buses: _____

Do the applicant's functional abilities to travel change due to medical treatments, environmental conditions (heat, humidity, cold, ice and snow) or other related factors? ☐ No ☐ Yes

If yes, what are the conditions and/or impact? _____



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Can the applicant do the following:

- | | |
|--|---|
| <input type="checkbox"/> Able to wait outdoors for 10 minutes | <input type="checkbox"/> Ride the fixed routes when not feeling well |
| <input type="checkbox"/> Stand for more than 15 minutes | <input type="checkbox"/> Walk or wheel ¼ mile (3 blocks) without assistance |
| <input type="checkbox"/> Ride the fixed routes when feeling well | |

Is the applicant able to be left alone: ☐ Yes ☐ No

Weight of applicant with their mobility device (if applicable): _____

Is applicant on dialysis? ☐ Yes ☐ No

Does the applicant have a hearing impairment? ☐ Yes ☐ No

Please describe any other disability or effect that prevents the applicant from using the accessible fixed route bus service.

Is there any other information you want to provide that will help us in making an appropriate eligibility determination? _____

Cognitive Disability

What is the formal diagnosis of the applicant's condition? _____

Does the applicant of any specific behavioral problems? _____

Is the applicant able to travel alone? ☐ Yes ☐ No

Is the applicant able to:

- | | | |
|---|------------------------------|-----------------------------|
| Give addresses and phone numbers upon request? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Able to recognize a destination or landmark? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Able to deal with unexpected situations or unexpected changes in routine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Does the applicant have the ability to follow directions? ☐ 1 Step Directions ☐ 2 Step Directions
☐ 3 Step Directions ☐ None



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Would the applicant know what to do if he/she became lost while out in the community? ☐ Yes ☐ No

Would the applicant know what to do if he/she became lost while out in the community? ☐ Yes ☐ No
If No, explain: _____

Does the applicant have the ability to safely cross streets? ☐ Yes ☐ No

Please check all that apply to applicant and provide additional information if necessary:

☐ Problem Solving

☐ Processing

☐ Short-term Memory

☐ Foresight/Planning

☐ Attention

☐ Safety Awareness/Judgment

How would these prevent the applicant from being able to safely use the fixed route service?

Behavioral/ Psychiatric

What is the formal diagnosis of the applicant's condition? _____

What is the prognosis for this condition for independent function? _____

Has the applicant been prescribed medications for his/her condition? ☐ Yes ☐ No

If yes, does this medication allow the applicant to function safely in the community? ☐ Yes ☐ No

Does the applicant experience auditory or visual hallucinations? ☐ No ☐ Yes

If yes, how do the hallucinations impair the applicant's ability to function in the community? _____

Does the applicant have anxiety or panic attacks in closed/crowded spaces? ☐ No ☐ Yes

Please explain _____

Are there life skills that the applicant lacks that would prevent him/her from safely using regular city buses? ☐ No ☐ Yes If yes, please explain _____

Seizure Disorders

Type(s) of seizures? _____

How often do the seizures occur? _____

Date of most recent seizure _____



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After a seizure, how long does it take before the applicant is able to function safely?

What triggers the applicant's seizure? _____

Is the applicant taking medication for the seizures? ☐ Yes ☐ No

Are the seizures currently controlled? ☐ Yes ☐ No

Is applicant able to function safely and effectively in the community? ☐ Yes ☐ No

Vision

What is the formal diagnosis of the applicant's condition? _____

What is the prognosis? Is this condition stable, degenerative or otherwise changing? _____

Best corrected Acuity : Right Eye _____ Left Eye _____ Both Eyes _____

Visual Fields: Right Eye _____ Left Eye _____ Both Eyes _____

Is the individual able to walk outdoors alone? ☐ Yes ☐ No

If yes, where can the applicant walk?

- ☐ Only on his/her own property and to familiar places
- ☐ To places nearby (for example, on the same block)
- ☐ To places further away

If applicant is able to travel outdoors alone, is he/she able to cross streets without help?

- ☐ At quiet streets with very little traffic
- ☐ At traffic lights
- ☐ At busy intersections
- ☐ With auditory cross signals only
- ☐ Other _____

If the applicant is partially sighted:

Is he/she able to see steps or curbs? ☐ Yes ☐ No

Is his/her vision affected by different lighting conditions?

- ☐ Bright sunlight
- ☐ Dimly lit or shaded places
- ☐ Nighttime
- ☐ Other



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Is the applicant's ability to travel outside alone affected by other conditions? ☐ Yes ☐ No (Consider impact of environmental noise and ability to distinguish traffic flow patterns.

Please explain: _____

Based upon my professional knowledge of the applicant, I certify that the preceding information is true and correct.

Name of Health Care Provider (Please Print) Office Phone Number

Office Street Address City State Zip Code

License Number/State Issued (Must be Current) Specialization

Signature _____ Date _____