UPDATED APPLICATION – PLEASE READ CAREFULLY

Dear Applicant,

The Americans with Disabilities Act (ADA) of 1990 is federal legislation that supports the rights of people with disabilities to participate more fully in community life. As required by the ADA, all Community and Everett Transit buses and facilities are fully accessible for people with disabilities. For ease of entry, all buses kneel (lower to ground level), or have ramps and/or lifts. In addition, other accommodations such as wheelchair securement areas, audible and visual stop announcements, and free training to learn how to use the bus (call 425 348-2379 for more information), make regular bus service possible for most people with disabilities.

The existence of a disability does not, by itself, qualify you for paratransit service. Eligibility is based solely on your functional ability to use the regular bus. If the effects of your disability prevent you from getting to/from a bus stop, waiting for a bus, getting on/off a bus, or navigating the bus system, you may be eligible for some level of paratransit service. Eligibility determinations are based upon the limitations caused by your disability and will be tailored to your individual abilities. You may qualify for partial or full service.

Paratransit service is similar to the regular bus in fare structure, days, hours, and service area. Our service is available within 3/4 mile of the regular, fixed-route bus route, on the same days and during the same hours the regular bus service is offered.

After you submit your application, we may request you to participate in an in-person functional assessment. Your application will not be considered complete until all requested information is provided to us. Once we have received all of the necessary information, an eligibility determination will be made within 21 days. You will be notified by mail of the decision.

(over)

Homage Senior Services
Well-being as we age

Eligibility determination provided by
Homage Senior Services
5026 196th St SW, Lynnwood, WA 98036
425-347-5912 800-562-1381

If you feel that, due to the effects of your disability, you are unable to successfully travel using the regular bus, some or all of the time, please complete the application form.

- ☐ Complete pages 1-5 of the application form (please print clearly)

- ☐ Ensure the applicant, legal Guardian, or, if applicable, their Power of Attorney (POA) signs the application on page 5. **If signed by a Guardian or POA, current documentation must be included with the application**. A signature is required before an application will be processed.

    - If the applicant has a guardian, the guardian is required to sign the application.

    - The parent or legal guardian of a minor is required to sign the application

- ☐ Ensure page 6 is completed and signed by an approved provider (see list of approved providers on page 5).

- ☐ Everything must be completed and legible or the application will be returned.

Mail the completed and signed application, and any appropriate or supporting paperwork, to:

Rider Eligibility
5026 196th St SW
Lynnwood, WA 98036

Please contact Customer Service, at 425 347-5912, with any questions.

Sincerely,

Deborah Perry
ADA Eligibility Specialist

Homage Senior Services
Well-being as we age

Eligibility determination provided by
Homage Senior Services
5026 196th St SW, Lynnwood, WA 98036
425-347-5912 800-562-1381

DART USE ONLY ☐ NEW ☐ RECERT Client # _____ T _____ E _____

LAST NAME _____ FIRST NAME _____ INITIAL _____

ADA Code _____ Temp _____ Duration _____ INC / DEN / CERT Date _____ Agency _____

ACS _____ Date _____ Status _____ Funding Code _____ FA _____ Due By _____

Paratransit Application for Dial a Ride (DART) and Everett Para Transit

This application is <u>exclusively</u> for current residents of <u>Snohomish County, Washington</u>.

<u>Part 1: Applicant Information *(please write clearly)*</u>

Last name_____First name_____Middle initial _____

Date of birth_____-_____-_____ Gender (please circle) M F

Residence address _____ Unit/Sp/Apt # _____

City_____State_____Zip_____

Name of Complex or Facility: _____

Home Phone _____ Cell Phone _____

Mailing address, if different: Name _____

Street or PO Box _____ Unit/Sp/Apt # _____

City_____State_____Zip_____

Emergency Contact: Name _____

Relationship:_____ Home #_____ Cell #_____

<u>Part 2: Qualifying Disability Information *(please write clearly)*</u>

1. List the health condition or disability that would prevent your use of the fixed route bus, some or all of the time? List **<u>only</u>** the ones that impact your ability to use to regular bus, and be specific.

Diagnosis / Disability	Severity	Date diagnosed

2. Please explain how the condition or disability:

Prevents you from getting to or from a regular, fixed route bus stop?

_____
_____

Prevents you from waiting at a regular, fixed route bus stop?

_____
_____

Prevents you from getting on or off a regular bus?

_____
_____

Prevents you from being able to ride a regular, fixed route bus or to understand and follow transit instructions?

_____
_____

General:

- Are you on any medication that affects your functional abilities? Yes _____ No _____

  If yes, specifically what side effect(s) are you experiencing?

  _____
  _____

Physical mobility (*if applicable*): Permanent _____ Temp / Expected duration _____

- Is walking detrimental to your condition? _____

  How far can you walk, with or without a mobility aid? _____

  Specifically, what, if anything, limits your ability to walk?

  _____

- Circle any of the following that you are unable to do, with *or* without a mobility aid?
  Up/down a moderately steep hill Uneven terrain Stand for 20 minutes
  Tolerate cold Tolerate heat

Seizures (*if applicable*): Permanent _____ Temp / Expected duration _____

- Type and frequency of seizure? _____

Vision (*if applicable*): Permanent _____ Temp / Expected duration _____

- What is your uncorrected visual acuity? R:_____ L: _____
- What is your corrected visual acuity? R: _____ L: _____
- Have you had mobility training related to your vision impairment?
  Yes _____ No _____ Unknown _____

Cognitive (*if applicable*): Permanent _____ Temp / Expected duration _____

- Are you able to follow verbal directions? Yes _____ No _____
- Are you able to follow written directions? Yes _____ No _____
- Are you able to maintain personal safety in the community (i.e. cross streets, interact with strangers, get help if lost, etc.)? Yes _____ No _____

Psychological (*if applicable*): Permanent _____ Temp / Expected duration _____

- Please answer questions under Cognitive section above.
- Are there any behavioral issues that would impact your use of public transportation (which is what paratransit is)? If so, what are they?

  _____

  _____

- Are your mental health issues currently controlled by medication?
  Yes _____ No _____ At times _____

Part 3: Mobility (please write clearly)

1. How have you most recently been traveling? **CHECK ALL THAT APPLY:**

☐ Community Transit Bus	☐ DART	☐ Walk
☐ Everett Transit Bus	☐ Everett Paratransit	☐ Bicycle
☐ Metro Transit Bus	☐ Access Paratransit	☐ Drive
☐ Sound Transit Bus	☐ Hopelink	☐ Taxi
☐ Train		☐ Ride in a Car

If you are able to drive, will you be doing so in the future? Yes ___ No ___

2. Have you ever used the regular, fixed route buses independently?
   - ☐ Yes, I typically used regular buses _____ a week.
   - ☐ Yes, I used to but stopped because (please be specific)

     _____
   - ☐ No

3. What accommodations would assist you in using the fixed route bus system?

☐ Route & schedule information	☐ Bus stops closer to home/destination
☐ Accessible bus stop and pathway	☐ Bench/shelter at bus stop
☐ No transfers	☐ Training to use the fixed route bus

☐ Other _____

4. Because of your disability do weather conditions (such as heat, cold, rain, snow, or ice), terrain conditions (such as hills, uneven surfaces, or curbs), or environmental conditions (such as darkness, bright lighting, or air quality) prevent you from using a regular bus independently?

☐ No ☐ Yes - which ones and how?

_____

_____

_____

5. Which of the following mobility aids or equipment do you use when you travel outside of your home? Check all that apply.

☐ None	☐ Walker (non-folding)	☐ White Cane
☐ Leg Brace	☐ Manual Wheelchair	☐ Service Animal
☐ Cane/Crutches	☐ Power Wheelchair	☐ Portable Oxygen
☐ Walker (folding)	☐ Power Scooter	☐ Bus lift

Which mobility aid would you primarily use on paratransit? _____

6. If you use a wheelchair or scooter:

Make & Model _____ Total length _____

Total width _____ Chair weight _____ Applicant weight _____

If you use a manual wheelchair: how far are you able to self-propel? _____

If you use a power wheelchair/scooter: How far are you able to travel outside on your own? _____

What would limit your abilities? _____

7. Do you need to travel with a Personal Care Attendant (PCA)?

A PCA is someone who travels with someone who cannot travel alone.

☐ No - you may still have a companion travel with you whenever you wish.

☐ Sometimes - at your discretion. You must arrange for your own PCA.

☐ Yes - if you check this box you are saying that you will **always** have a PCA with you. You understand that you must provide your own PCA as our drivers may not serve as one.

If you answered "No" or "Sometimes" above, do you require assistance from your door to the bus?

☐ No ☐ Yes. What type of assistance? _____

Part 4: Applicant Verification

Note: For the safety of everyone, DART and Everett Paratransit vehicles are equipped with audio and video recording devices.

I certify under penalty of perjury (RCW 9A.72.030) that the information provided in this application is true and correct to the best of my knowledge. I understand that falsification of information may result in denial of service and criminal penalty. I understand that information provided on this application will be disclosed to others as necessary to provide the services I have requested and as otherwise may be required by law.

This form must be signed by the applicant, their Guardian, or, if applicable, by the applicant's Power of Attorney (POA). If the applicant is under 18 years of age, a parent or legal guardian must sign this form. **If the application is signed by a legal guardian or POA, current documentation supporting the right to sign must be enclosed.**

_____ _____

Signature (required) Date

☐ Applicant ☐ Legal Guardian ☐ Power of Attorney

_____ _____

Printed Name Contact number

If a person other than the applicant filled out this application, please complete the following (please print).

Name _____ Phone # _____

Relationship to Applicant _____

Please Note: A licensed Medical or Mental Health provider, one who is **most** familiar with you and your disability/limiting condition, must answer the questions on page 6 of this application form. Approved providers are limited to the following professions.

My approved provider is a (please check the appropriate box below):

☐ Medical Doctor (MD or DO)	☐ Psychologist (Ph.D.)
☐ Physician Assistant or ARNP	☐ Mental Health Clinician III or IV
☐ Ophthalmologist or Optometrist	☐ Audiologist (certified by ASHA)
☐ Certified Orientation & Mobility Specialist	☐ LICSW (employed at medical facility)

Part 5: Professional Verification

Applicant Name _____

Thank you for completing this application. We will use the information to help determine paratransit eligibility in accordance with the Americans with Disabilities Act (ADA). Paratransit is a tax-supported service for individuals who, because of the effects of their disabilities/limiting conditions, are not able to ride the regular ramp-equipped and accessible bus. **Age, language, convenience of the service, fear of falling, inability to drive, and inability to carry packages are not qualifying factors for paratransit service**. Please call 425 347-5912 if you have any questions.

Please review the information provided by the applicant on this application form. Based on your knowledge of the applicant's condition, is the information accurate? ☐ Yes ☐ No ☐ Somewhat

If you checked *No* or *Somewhat*, please explain _____
_____
_____
_____

Are there any changes or additions you would make to the list of stated Diagnosis/Disability shown on page 1, Part 2 of this application? _____
_____
_____
_____

Provide any additional information that you deem relevant as to why the effects of the applicant's disability/limiting condition will prevent their use of the regular, fixed route bus system.
_____
_____
_____

I am an approved provider (see page 5), licensed in Washington State in the field indicated below, and certify that the above-mentioned individual has the disability and limitations indicated above (RCW A.72.085 & RCW 40.16.030)**.**

_____ _____
Professional Care Provider's Signature Date

_____ _____
Professional Care Provider's Name (Please Print) Phone

_____ _____
Mailing Address Clinic Name

_____
Individual National Provider Identifier (NPI) or WA DOH License number
***This form considered incomplete without valid <u>individual</u> number.**