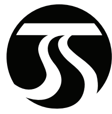

# Paratransit Service Application Form

**Thank you for your interest in Spokane Transit Paratransit service!**

All persons seeking eligibility for Paratransit service must complete the eligibility process that begins with completing this application form. For more information, see the Paratransit Eligibility brochure included with the application form or go to www.spokanetransit.com.

If you have any questions or need assistance completing this application form, we are happy to help you. Please call (509) 325-6052 for assistance.

**INSTRUCTIONS**

Before submitting the application form, please:

- ☐ Read the Paratransit Eligibility brochure included with the application form.
- ☐ Complete pages 1-5 of this application form. *Please print clearly*.
- ☐ Ensure the applicant or, if applicable, Legal Guardian or Power of Attorney (POA) signs the application form on page 4. **A signature is required before an application will be processed.**
  - ► If you have a legal 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 a medical/mental health provider. (See list of approved providers on page 5.)

ADDITIONAL ATTACHMENTS REQUIRED FOR A LEGAL GUARDIAN OR POA

- ☐ Provide copies of current Letters of Guardianship and the Order Appointing Guardian document from the court.
- ☐ Power of Attorney paperwork must include current documentation that grants the POA the right to sign a medical release form on behalf of the applicant.
  - ► Spokane Transit may require written documentation verifying the POA is in effect.

**All 8 pages of the completed application form must be returned at the same time.**

Your application for service is not complete until all required information is provided to Spokane Transit.

☐ New ☐ Recert

ID # ____________ Exp: ____________

# PARATRANSIT SERVICE APPLICATION FORM

REVISED 1/2017

Last Name ____________ First Name ____________ M.I. ____

Mailing Address ____________ Apt./Sp. # ____

City ____________ State ____ Zip ____________

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The address where Paratransit will pick you up (if different from mailing address)

Street Address ____________ Apt./Sp. # ____

City ____________ State ____ Zip ____________

Date of Birth ____________ ☐ Male ☐ Female
MM/DD/YYYY

Home Phone (____) ____________ Cell Phone (____)____________

Email Address ____________

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Emergency Contact ____________ Relationship ____________

Home Phone (____) ____________ Cell Phone (____)____________

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If we are unable to contact you, please list an alternative contact

Name ____________ Relationship ____________

Home Phone (____) ____________ Cell Phone (____)____________

By providing emergency/alternate numbers, you authorize STA or its representatives to contact the individuals listed regarding your Paratransit service.

Do you speak and understand English? ☐ Yes ☐ No (specify other language below)

____________

Applicant's Name ______________________________

1. What is your disability or limiting condition? ______________________________

2. Do your limitations change from time to time because of medical treatments, medications, or for other reasons? ☐ Yes ☐ No

   If yes, please explain: ______________________________

3. Is your need for Paratransit service long term or temporary?

   ☐ Long term ☐ Temporary - How long? ______________________________

4. Is your memory affected due to your disability/limiting condition? ☐ Yes ☐ No

   If yes: ☐ Short-term memory ☐ Long-term memory

5. Do you currently ride the regular bus? ☐ Yes ☐ No

   Have you ever ridden the regular bus without someone's assistance?

   ☐ Yes ☐ No If yes, how long ago? ______________________________

6. Are you able to independently:

| | Yes | No | Sometimes |
|---|---|---|---|
| travel to and from a bus stop? | ☐ | ☐ | ☐ |
| get on and off a ramp-equipped bus? | ☐ | ☐ | ☐ |
| ask for, understand, and/or follow directions? | ☐ | ☐ | ☐ |
| plan, understand, and follow through with the actions necessary to take a bus trip? | ☐ | ☐ | ☐ |

If you checked *no* or *sometimes* on question 6, please explain. (Use additional lines on Page 8, if necessary.) ______________________________

Applicant's Name ______________________________

7. Which of the following mobility aids or equipment do you use when you leave your home? Check all that apply and indicate the percentage of time you use the aid (example: support cane, 90%, no aids, 10%).

| | | | |
|---|---|---|---|
| No aids | ____% | Motorized wheelchair | ____% |
| White cane | ____% | Motorized scooter | ____% |
| Support cane | ____% | Manual wheelchair | ____% |
| Crutches | ____% | Other (please specify) | ____% |
| Walker | ____% | ______________________ | |

8. If you checked more than one aid, please describe the circumstances when you use each one. ______________________________

______________________________

______________________________

______________________________

*If you use a scooter or wheelchair, skip to question 10.*

9. When you **walk** outside your home, how far can you walk by yourself or with the use of a mobility aid such as a cane or walker?

   Number of blocks ______ ☐ Less than 1 block ☐ Not able to walk any distance

10. If you use a **manual wheelchair**, how far are you able to self-propel?

    Number of blocks ______ ☐ Less than 1 block ☐ Unable to self-propel

11. If you use a **power wheelchair or scooter**, how far are you able to travel without someone's assistance?

    Number of blocks ______ ☐ Less than 1 block ☐ Not able to travel any distance

12. If you qualify for Paratransit service, will you need to:

| | Yes | No | Sometimes |
|---|---|---|---|
| use the lift to board the van? | ☐ | ☐ | ☐ |
| bring a helper (Personal Care Attendant - PCA) with you? | ☐ | ☐ | ☐ |

13. Is there anything else about your disability/limiting condition that might help us better understand your travel abilities and limitations? (Use additional lines on Page 8, if necessary.) ______________________________

______________________________

______________________________

______________________________

Applicant's Name ______________________________

## Paratransit Service Applicant Agreement and Authorization for Release of Information

By signing this application, you authorize the release of verification information and any other information to Spokane Transit or its representatives needed to evaluate your eligibility to receive Paratransit service. Please be advised that Spokane Transit will use your statements to determine your eligibility for Paratransit service as provided by law. The statements contained herein are material to Spokane Transit's determination and Spokane Transit may act in reliance thereon.

Spokane Transit may share your eligibility determination with other transportation providers, on request, to facilitate travel in Spokane and other transit districts.

Documents used by Spokane Transit regarding your Paratransit eligibility, with the exception of information provided by your medical provider, may be subject to public disclosure in response to a public records request under Chapter 42.56 RCW. Spokane Transit will attempt to notify you should there be a public records request for your eligibility documents.

This form must be signed by the applicant or, if applicable, by the applicant's legal guardian or 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, attach current documentation supporting the right to sign.

**I hereby certify under the penalty of perjury under the laws of the State of Washington that the information provided on this application is true and correct.**

______________________________ ______________

Signature (required) Date

☐ Applicant ☐ Legal Guardian ☐ Power of Attorney

______________________________ ______________

Printed Name Contact number

Applicant's Name ______________________________

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

Name ______________________ Daytime Phone # ______________

Relationship to Applicant ______________ Agency ______________

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**Please Note:** A licensed Medical or Mental Health provider, who is 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)

☐ Licensed Mental Health Professional

☐ Optometrist or Ophthalmologist

☐ Physical or Occupational Therapist

☐ Psychologist (Ph.D.)

☐ MDS Nurse (From Skilled Nursing Facilities Only)

☐ Physician Assistant or ARNP

☐ Certified Orientation & Mobility Specialist

If you have been told there is a charge for obtaining medical or mental health verification, call (509) 325-6052. Spokane Transit may be able to identify an alternative service that does not charge for the required verification.

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**Please have your approved licensed provider complete page 6 of this Paratransit Application Form.**

Applicant's Name ______________________________

**LICENSED PROVIDER VERIFICATION**

Thank you for completing this application. Spokane Transit 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 STA bus. **Age, convenience of the service, fear of falling, inability to drive, and inability to carry packages are not qualifying factors for Paratransit service**. Please call (509) 325-6052 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: ______________________________

______________________________

| DIAGNOSIS/DISABILITY (not symptoms) | DEGREE OF IMPAIRMENT (circle one) | DATE OF ONSET (if known) |
|---|---|---|
| ______________ | mild moderate severe | ______________ |
| ______________ | mild moderate severe | ______________ |
| ______________ | mild moderate severe | ______________ |
| ______________ | mild moderate severe | ______________ |
| ______________ | mild moderate severe | ______________ |

Is the applicant's need for Paratransit service temporary? ☐ Yes, until ______________ ☐ No

If the applicant has a condition that is expected to improve, i.e. knee replacement or recent stroke, when do you expect the condition to stablize? ______________________________

Are any of these conditions episodic or variable in their severity? ☐ Yes - provide details below ☐ No

______________________________

______________________________

______________________________

Provide any additional information that you deem relevant as to why the effects of the applicant's disability/limiting condition will prevent the applicant from using the regular bus service.

______________________________

______________________________

______________________________

I HEREBY CERTIFY under penalty of perjury under the laws of the State of Washington that the information on the Provider Verification portion of this application form is true and correct.

______________________ / ______________________ / ______________

Licensed Provider's Signature / Specialty / Date

______________________ / ______________________ / ______________ / ______________

Printed Name / Organization / Phone / Fax

______________________ / ______________________ / ______________

Address / City / State/Zip

## APPLICANT

**Thank you for providing the information STA needs to determine your eligibility for Paratransit. After Spokane Transit reviews your completed application form, you will be notified if additional information is required. STA will make the eligibility determination within 21 calendar days of receiving all the required information, and written notice will be sent to you.**

**If it takes longer than 21 days to finalize your eligibility, we will notify you that you qualify for temporary Paratransit service until the eligibility determination is made.**

**Please keep all 8 pages of this application together and return at the same time.**

**Fold the form in half and return it to the address on the back page or FAX to (509) 232-6784.**

**Paratransit**
**Spokane Transit**
**1230 West Boone Avenue**
**Spokane, WA 99201**

Spokane Transit assures nondiscrimination in accordance with Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act. For more information, visit www.spokanetransit.com. All phone numbers are accessible for people who are deaf or hard of hearing through Relay 711.

Upon request, alternative formats of this document will be produced for people who are disabled. Call (509) 325-6094 or email ombudsman@spokanetransit.com.

# ADDITIONAL INFORMATION

6. ______________________________

13.

Other:

**Please fold in half**

U.S.
Postage
Required

**Paratransit**
**Spokane Transit**
**1230 West Boone Avenue**
**Spokane, WA 99201**