



# ADA Paratransit Application

## Overview – Services Available

**B-Line ADA Paratransit** provides curb-to-curb transportation service in accordance with the Americans with Disabilities Act of 1990 (ADA). This service is provided to individuals who, because of a physical or mental disability, are unable to use the regular Fixed Route bus service in Butte County. The purpose of this application is to provide an opportunity for you to describe how your disability prevents you from riding the B-Line Fixed Route bus system, and in doing so apply for B-Line ADA Paratransit. Age, distance from a bus stop or inability to drive are conditions which are not taken into consideration in making an eligibility determination.

### **Travel Training**

If you are interested in receiving free travel training to learn how to use our regular Fixed Route buses, please call Mains'1 at 530-894-2057, extension 372. You can also call B-Line at 530-809-4616 for information.

***B-Line must have the completed Paratransit Eligibility Application including the Healthcare/Social Service Release of Information portion to begin the determination of eligibility. We will return the application to you if we are missing any signatures or other information.***

In accordance with ADA regulations, a determination of eligibility will be made within 21 calendar days after receipt of your **completed** application.

### **B-Line Paratransit**

326 Huss Drive, Suite #150, Chico, CA 95928

Phone: (530) 809-4616 Fax: (530) 879-2444 Web: [www.BLineTransit.com](http://www.BLineTransit.com)

## Personal/Contact Information

|  |                          |   |   |   |
|--|--------------------------|---|---|---|
| New Applicant  | Renewal                  | Last Name                                 | First Name                                | MI  |
| <input type="checkbox"/>   | <input type="checkbox"/> | <input style="width: 100%;" type="text"/> | <input style="width: 100%;" type="text"/> | <input style="width: 100%;" type="text"/>                     |
| Street Address:  |                          |   |   | Apt/Bldg #  |
| <input style="width: 100%;" type="text"/>  |                          |   |   | <input style="width: 100%;" type="text"/>                     |
| City:  |                          |   | State:                                    | Zip Code:   |
| <input style="width: 100%;" type="text"/>  |                          |   | <input style="width: 100%;" type="text"/> | <input style="width: 100%;" type="text"/>                     |
| Home Phone:  |                          | Work or Cell Phone:                       |   | Date of Birth   |
| <input style="width: 100%;" type="text"/>  |                          | <input style="width: 100%;" type="text"/> |   | <input style="width: 100%;" type="text"/>                     |
| Email Address:   |                          |   |   | Gender:   |
| <input style="width: 100%;" type="text"/>  |                          |   |   | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| <b>Do you need a Personal Care Attendant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> For Certain Trips  |                          |   |   |   |
| Checking Yes on Personal Care Attendant means you need someone to travel with you in order to successfully complete a trip. A PCA is not provided to you; it is your responsibility to bring one and they travel free of charge. |                          |   |   |   |

|   |  |   |                          |   |
|---|--|---|--------------------------|---|
| <b>Did you require assistance with this paratransit application process or will you need assistance with future correspondence/recertification?</b> |  |   | Yes                      | No  |
|   |  |   | <input type="checkbox"/> | <input type="checkbox"/>                  |
| If yes, to whom should important correspondence be mailed?  |  |   |                          |   |
| Last Name   |  | First Name                                |                          | Contact Phone:                            |
| <input style="width: 100%;" type="text"/>   |  | <input style="width: 100%;" type="text"/> |                          | <input style="width: 100%;" type="text"/> |
| Secondary Contact Mailing Address:  |  |   |                          | Relationship to Applicant:                |
| <input style="width: 100%;" type="text"/>   |  |   |                          | <input style="width: 100%;" type="text"/> |

|   |  |   |  |   |
|---|--|---|--|---|
| <b>Please provide the name and telephone number of someone we can call in case of an emergency:</b> |  |   |  |   |
| Last Name   |  | First Name                                |  | Contact Phone:                            |
| <input style="width: 100%;" type="text"/>   |  | <input style="width: 100%;" type="text"/> |  | <input style="width: 100%;" type="text"/> |

| Office Use Only (Do Not Write in this Box) |                             |
|--|-----------------------------|
| ID # _____                                 | Expiration Date: _____      |
| Date Received: _____                       | Date Issued: _____          |
| Certifier: _____                           | Eligibility Category: _____ |
| Comments:                                  |                             |

## Disability/Health– Related Information

Please answer the following questions in detail. Your answers will help us in determining your eligibility.

1. What is your medical condition(s)/disability?

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2. How does it prevent you from using the B-Line fixed route bus?

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3. Date of onset/when your disability first began: \_\_\_\_\_

4. Please read the following statements and check the one that best describes your disability:

I have a temporary disability and will only need paratransit service until I recover.

I have difficulty remembering all of the things I have to do to use the city bus.

I am able to ride the city bus independently.

I have a visual disability which prevents me from using the city bus.

I have a disability that causes me to have Good Days/Bad Days.

I can never use the city bus by myself.

I can use the city bus for some trips but not others.

I believe I can learn to ride the city bus if someone taught me.

5. Please indicate if you use any of the following mobility aids/equipment:

I do not require any assistive devices

Service Animal

Communication Board

Manual Wheelchair

White Cane

Picture/Alphabet Board

Power/Electric Wheelchair

Cane

Prosthesis

Sport Wheelchair

Walker

Leg Braces

Scooter

Crutches

Other (describe)

Segway

Portable Oxygen

\_\_\_\_\_

I understand that if my mobility device is longer than 48” or wider than 30”, or if the combined weight of the applicant and the device is more than 600 pounds, I will not be able to ride B-Line vehicles/equipment.

## Ability to Use Regular (Fixed Route) B-Line Buses

All regular fixed route buses have wheelchair lifts, handrails and kneelers (steps that lower to curb level) or ramps for ease in boarding.

**6. Do you use the regular fixed route bus INDEPENDENTLY?**

- Yes/Sometimes       No

**7. When is the last time you independently used the fixed route bus?**

- In the past month       In the past five years       Never  
 In the past year       In the past ten years

**8. Are there certain days/times you can use the fixed route bus but not others?**

- Yes       No       Sometimes  
 Don't know

If you have chosen Yes/Sometimes, please explain: \_\_\_\_\_

**9. How would you describe the terrain where you live (e.g. flat, hilly, dirt roads, lack of sidewalks, etc.)?**

\_\_\_\_\_

**10. How far from your home is the nearest public bus stop?**

- Less than 1 block       1-2 blocks       3-4 Blocks  
 5 or more blocks       I don't know

**11. Have you ever successfully completed travel training?**

- Yes       No

If you have chosen Yes, please elaborate with time frames & dates:

**12. Do you have hearing problems that would prevent you from using a fixed route bus?**

- Yes       No

If you have chosen Yes, please explain:

**13. Do you have a breathing problem that would prevent you from using a fixed route bus?**

- Yes       No

If you have chosen Yes, please explain:

\_\_\_\_\_

**14. Do you have a memory problem that would prevent you from using a fixed route bus?**

Yes       No

If you have chosen Yes, please explain:

**15. Do you have a balance problem that would prevent you from using a fixed route bus?**

Yes       No

If you have chosen Yes, please explain:

**16. Do you have a visual problem that would prevent you from using fixed route bus?**

Yes       No

If you have chosen Yes, please explain:

**17. Do you have a problem independently crossing the street?**

Yes       No

If you have chosen Yes, please explain:

**18. How far can you travel on your own or when using a mobility aid?**

- I can get to the curb in front of my home
- I can travel up to ¼ mile (3 blocks)
- I can travel up to ½ mile (6 blocks)
- I can travel up to ¾ mile (9 blocks)
- I can travel further than ¾ mile

**19. Do any of the following barriers prevent you from using the bus?**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Cold                                   | <input type="checkbox"/> Heat  | <input type="checkbox"/> Rain   |
| <input type="checkbox"/> Snow                                   | <input type="checkbox"/> Night Blindness                               | <input type="checkbox"/> Hills  |
| <input type="checkbox"/> Lack of Sidewalks                      | <input type="checkbox"/> Lack of curb cuts                             | <input type="checkbox"/> Bus stop not accessible                        |
| <input type="checkbox"/> Good/Bad Day                           | <input type="checkbox"/> Unable to transfer buses                      | <input type="checkbox"/> Light sensitivity (sunny, overcast, etc.)      |
| <input type="checkbox"/> Unable to walk/wheel 50 feet (1 block) | <input type="checkbox"/> Unable to walk/wheel ¼ mile (3 blocks)        | <input type="checkbox"/> Unable to walk/wheel ½ mile (6 blocks)         |
| <input type="checkbox"/> Unable to walk/wheel ¾ mile (9 blocks) | <input type="checkbox"/> Lack of strength and endurance (hyperfatigue) | <input type="checkbox"/> Uneven travel path (dirt road, potholes, etc.) |
| <input type="checkbox"/> Air Pollution (pollen – allergies)     | <input type="checkbox"/> None  |   |

**Applicant's Certification and Release of Information**

**Healthcare/Social Services Professional** *Please provide information for the professional who can best document the applicant's abilities.*

Name: \_\_\_\_\_

Profession: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

I certify that the information in this application is true and correct. I understand that knowingly falsifying any information may result in the denial of service by the Butte County Association of Governments/Butte Regional Transit (B-Line). I understand that all information will be kept confidential and only information required to provide the services I request will be disclosed to those who perform the services.

By signing below, I understand that I am giving my consent for B-Line to use and disclose my protected health information for the purposes of providing transit services.

I understand that my health care/social service provider may be contacted to verify information stated in my application for purposes of paratransit eligibility. I understand that my health information may be used by B-Line's transit provider, Transdev. I understand that it is my responsibility to notify B-Line if my condition changes and if my condition changes after I have been determined eligible, I may be asked to reapply. I also understand that I may revoke this consent at any time by notifying B-Line in writing of my intent to revoke this consent form.

I understand I have a right over my health information, including the right to restrict the use of my health information, to examine and obtain a copy of this application and to request corrections.

Applicant Signature

Date

# HIPAA Release Form

**This is giving your healthcare or social services office permission to speak to B-Line about your disability and functional mobility.**

Please complete **all sections** of this HIPAA release form. If any sections are left blank, this form will not be accepted.

Date: \_\_\_\_\_

I, \_\_\_\_\_, give my permission for the following office to share information with Butte Regional Transit (B-Line) regarding my functional mobility and disability status:

Healthcare/Social Services Office \_\_\_\_\_.

The reason for this disclosure is strictly for use in the paratransit application process by Butte Regional Transit Paratransit Staff. It will not be shared with anyone else. Butte Regional Transit strives to protect all passenger data and will store and dispose of any personal information in a secure manner.

This authorization is only valid until the paratransit application is processed, up to 21 days from receipt of the application. Authorization can be revoked at any time by submitting a request in writing to B-Line Paratransit at:

B-Line Paratransit  
326 Huss Drive, Suite 150  
Chico, CA 95928

Please sign below.

X

\_\_\_\_\_  
Applicant Signature

If you are filling this form out for someone else, please indicate your legal ability to sign for the applicant in the space below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_