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 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) 891-2979 Web: www.BLineTransit.com

Personal/Contact Information

New Applicant ☐ Renewal ☐ Last Name First Name MI

Street Address: Apt/Bldg #

City: State: Zip Code:

Home Phone: - - Work or Cell Phone: - - Date of Birth - -

Email Address: Gender: ☐ Male ☐ Female

Do you need a Personal Care Attendant? ☐ Yes ☐ No ☐ 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.

Did you require assistance with this paratransit application process or will you need assistance with future correspondence/recertification? Yes ☐ No ☐

If yes, to whom should important correspondence be mailed?

Last Name First Name Contact Phone: - -

Secondary Contact Mailing Address: Relationship to Applicant: _____

Please provide the name and telephone number of someone we can call in case of an emergency:

Last Name First Name Contact Phone: - -

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?

_____

_____

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

_____

_____

_____-

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
- ☐ Manual Wheelchair
- ☐ Power/Electric Wheelchair
- ☐ Sport Wheelchair
- ☐ Scooter
- ☐ Segway
- ☐ Service Animal
- ☐ White Cane
- ☐ Cane
- ☐ Walker
- ☐ Crutches
- ☐ Portable Oxygen
- ☐ Communication Board
- ☐ Picture/Alphabet Board
- ☐ Prosthesis
- ☐ Leg Braces
- ☐ Other (describe) _____

☐ **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?

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

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.

Signature Date

HIPAA Release Form

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I

I,_____, give my permission for _____to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II – Health Information

I would like to give the above healthcare organization permission to:

Tick as appropriate

☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

Or

☐ Disclose my complete health record except for the following information

- ☐ Mental health records
- ☐ Communicable diseases including, but not limited to, HIV and AIDS
- ☐ Alcohol/drug abuse treatment records
- ☐ Genetic information
- ☐ Other (Specify)

_____

_____

_____

_____

Form of Disclosure:

☐ Electronic copy or access via a web-based portal

☐ Hard copy

Section III – Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write ‘at my request’.

_____

_____

_____

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)

Name: _____

Organization: _____

Address: _____

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my health information is valid:

Tick as appropriate

☐ a) From_____to _____

Or

☐ b) All past, present, and future periods

Or

☐ c) The date of the signature in section VI until the following event:

_____

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Name: _____

Organization: _____

Address: _____

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.

- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI – Signature

Signature:_____ Date: _____

Print your name: _____

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form:

_____

_____

_____

_____