



ADA Paratransit Application

Overview – Services Available

B-Line provides two types of paratransit service, ADA paratransit and Dial-a-Ride. The following explains the two services and the required applications:

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 regular, fixed route bus service in Butte County. The purpose of this application is 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.

B-Line also has a **Dial-a-Ride** service available to individuals age 65+ and/or that have disabilities that do not necessarily prevent them from utilizing the fixed route bus system. **Dial-a-Ride trips will not be given priority status should individuals with ADA certification need the service and may be charged higher premium fares.** If you are interested in applying for Dial-a-Ride without ADA certification, a one page Dial-a-Ride application can be obtained from the B-Line office or the B-Line website www.BLineTransit.com.

Each application will be reviewed for eligibility. The more complete and accurate information you provide, the better B-Line staff will understand your abilities and travel challenges. ***B-Line must have the completed Paratransit Eligibility Application including the Healthcare/Social Service Verification portion to begin the determination of eligibility.*** After we receive both completed parts, you may be required to participate in an interview with B-Line staff.

**ATTENTION HEALTHCARE/SOCIAL SERVICE PROFESSIONALS:
PLEASE TURN TO PAGE 7 TO FILL OUT YOUR PORTION OF THIS
APPLICATION.**

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
2580 Sierra Sunrise Terrace, Suite 100, Chico, CA 95928
Phone: (530) 879-2468 Fax: (530) 891-2979 Web: www.BLineTransit.com

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 and how does it prevent you from using the B-Line fixed route bus?

2. Date of onset/when your disability first began: _____

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

- | | | |
|--|--|--|
| <input type="checkbox"/> I have a temporary disability and will only need paratransit service until I recover. | <input type="checkbox"/> I have difficulty remembering all of the things I have to do to use the city bus. | <input type="checkbox"/> I am able to ride the city bus independently. |
| <input type="checkbox"/> I have a visual disability which prevents me from using the city bus. | <input type="checkbox"/> I have a disability that causes me to have Good Days/Bad Days. | <input type="checkbox"/> I can never use the city bus by myself. |
| <input type="checkbox"/> I can use the city bus for some trips but not others. | <input type="checkbox"/> I believe I can learn to ride the city bus if someone taught me. | |

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

- | | | |
|---|--|---|
| <input type="checkbox"/> I do not require any assistive devices | <input type="checkbox"/> Service Animal | <input type="checkbox"/> Communication Board |
| <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> White Cane | <input type="checkbox"/> Picture/Alphabet Board |
| <input type="checkbox"/> Power/Electric Wheelchair | <input type="checkbox"/> Cane | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Sport Wheelchair | <input type="checkbox"/> Walker | <input type="checkbox"/> Leg Braces |
| <input type="checkbox"/> Scooter | <input type="checkbox"/> Crutches | <input type="checkbox"/> Other (describe) |
| <input type="checkbox"/> Segway | <input type="checkbox"/> 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.

5. Do you use the regular fixed route bus INDEPENDENTLY?

- Yes/Sometimes No

6. 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

7. 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: _____

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

9. 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

10. Have you ever successfully completed travel training?

- Yes No

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

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

- Yes No

If you have chosen Yes, please explain:

12. 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:

13. 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:

14. 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:

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

Yes No

If you have chosen Yes, please explain:

16. Do you have a problem independently crossing the street?

Yes No

If you have chosen Yes, please explain:

17. 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

18. 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

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, Veolia Transportation. 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

Section 2 – Healthcare Information

Healthcare/Social Service Professional Verification for ADA Paratransit Eligibility – To Be Completed by Professional who Can Best Document Applicant's Abilities (a License is not required)

Your client/patient is applying for B-Line's Americans with Disabilities Act (ADA) Paratransit service. To be eligible for this service, an individual must be unable to independently use accessible fixed routes. Please note that all fixed route buses are equipped with ramps and lifts, thus eliminating the need to negotiate stairs. Fixed route buses offer accessibility features like priority seating for seniors and individuals with disabilities, driver assistance on and off the bus, etc. This section must be completed by a healthcare/social service professional in order to submit this application. **Your participation is vital, as incomplete applications will be deemed ineligible and your client will not be able to use the ADA paratransit service.**

The information shared will be protected per Health Insurance Portability and Accountability Act (HIPAA) requirements, and your client/patient has agreed to allow B-Line/Butte County Association of Governments (BCAG) to contact you for the information in this application. Your cooperation and assistance is greatly appreciated. If you have any questions or comments please do not hesitate to contact us at (530) 879-2468.

Please return completed form to client or submit ENTIRE application package (including client portion) to: B-Line Paratransit, 2580 Sierra Sunrise Terrace, Suite 100, Chico, CA 95928
or Fax to: (530) 891-2979

CLIENT NAME: _____

1. Which statement best describes your client's condition?

- Being treated and is expected to improve Permanent condition that is not expected to change Disease is advanced and considered terminal

2. Will condition interfere with independent fixed route bus usage?

- Yes No Sometimes (explain) _____

3. If condition is temporary, please provide anticipated date client can resume normal travel: _____

4. Have you ever prescribed or are you aware of a device your client currently uses?

- | | | |
|---|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Cane | <input type="checkbox"/> Picture/Alphabet Board |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Walker | <input type="checkbox"/> Communication Board |
| <input type="checkbox"/> Scooter | <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Portable Oxygen |
| <input type="checkbox"/> Leg Braces | <input type="checkbox"/> Sport Wheelchair | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Service Animal | <input type="checkbox"/> Power/Electric Wheelchair | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> White Cane | <input type="checkbox"/> Segway | |

5. Are your client's symptoms episodic?

Yes No Sometimes

If you have chosen Yes/Sometimes, please elaborate:

6. Are you aware of any challenges your client has with balance or strength and endurance?

Yes No Sometimes

If you have chosen Yes/Sometimes, please elaborate:

7. Do you think your client could independently ambulate/wheel $\frac{3}{4}$ mile (with a mobility device and brief rest periods if needed)?

Yes No Sometimes

If you have chosen Yes/Sometimes, please elaborate:

8. Are you aware of any challenges your client has with memory?

Yes No Sometimes

If you have chosen Yes/Sometimes, please elaborate:

9. Are you aware of any challenges your client has with breathing?

Yes No Sometimes

If you have chosen Yes/Sometimes, please elaborate:

10. Are you aware of any challenges your client has with ambulating on hills?

Yes No Sometimes

If you have chosen Yes/Sometimes, please elaborate:

11. Do you have any safety concerns for your client/patient in using a regular fixed route bus by themselves (e.g. compromised immune system, panic attacks, cognitive deficits, risk of falling, etc.)?

Yes No Sometimes

If you have chosen Yes/Sometimes, please elaborate:

12. Will inclement or extreme hot/cold weather have an impact on your client's abilities to use a fixed route bus?

Yes No Sometimes

If you have chosen Yes/Sometimes, please elaborate:

13. Are you aware of any visual impairment that may challenge your client in using a fixed route bus?

Yes No Sometimes

If you have chosen Yes/Sometimes, please elaborate:

14. Are you aware of any hearing impairment that may challenge your client in using a fixed route bus?

Yes No Sometimes

If you have chosen Yes/Sometimes, please elaborate:

15. Are you aware of any inappropriate social behavior exhibited by your client?

Yes No Sometimes

If you have chosen Yes/Sometimes, please elaborate:

16. Do you have any additional comments that may help document your client's abilities/challenges in getting to, using, and commuting on a bus?

Yes No If yes, please elaborate:

17. Please provide your professional contact information:

Name: _____

Profession/Agency: _____

License # (if applicable): _____

Address : _____

Phone #: _____ Email : _____

18. I certify that all statements made herein are true and accurate to the best of my knowledge.

Professional Signature

Date

Please return completed form to client or submit ENTIRE application package (including client portion) to:

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