

## Americans with Disabilities Act (ADA)

**Paratransit Eligibility Application Packet**

### Volusia County Public Transit

### Eligibility

ADA Paratransit Service is in accordance with the Americans with Disabilities Act (ADA) of 1990. Individuals applying for Votran’s ADA Paratransit services must demonstrate an inability to use the Votran Fixed Route transit system. Disability alone does not create eligibility for ADA Paratransit Services. The decision is based solely on the applicant’s functional ability to use fixed route buses.

There are three (3) types of certifications granted to eligible Votran clients:

* **Permanent Certification:** The individual has a permanent condition that will not improve that *always* prevents the use of the Votran Fixed Route Bus.
* **Conditional Certification:** The individual can use, or learn to use, the Votran Fixed Route Bus, but their condition prevents some travel on the Bus. Votran Paratransit may be provided on qualifying trips where the individual is unable to take the bus.
* **Temporary Certification:** The individual has a specific, short-term condition that prevents them from using the Votran Fixed Route Bus. Or, the individual is eligible for paratransit services on a different transit system and is visiting the area. Proof of eligibility on the individual’s local system may be required. Certification length will be on a case-by-case basis.

**VOTRAN USE ONLY**

|  |  |
| --- | --- |
| New Recertification | Fixed Route Referral Yes No |
| Date Received: Reviewed by: | Approved: Denied:  |
| Funding Source: ADA | Scheduled Travel Training Date:  |
| Medicaid Yes No QMB SLMB Inactive | Scheduled Functional Assessment: |
| Medicaid Number:  | PCA needed: Yes No |

**Steps in the Eligibility Process**

1. Request/receive an Application Packet
2. Read the Eligibility Guide
3. Complete ALL questions on the ADA Paratransit Application
4. Submit your Professional Verification Form if required to do so. This form should be completely filled out and signed by one of the professionals listed on the form.
5. Send in your application via mail or fax:
* **Mail:** Votran
1. Big Tree Road,
2. South Daytona FL, 32119
* **Fax:** (386) 322-5119

Your eligibility will be determined within 21 days from the date your **COMPLETE**

application is received by the Votran Office.

##### EVERY QUESTION MUST BE ANSWERED.

**AN INCOMPLETE APPLICATION WILL BE RETURNED AND WILL DELAY**

**PROCESSING. *All applications are confidential.***

### Application for ADA Eligibility Certification

*This application must be filled out entirely in order to be processed.*

**

New Applicant

#### Applicant Information

 Recertification

Name: Birth Date: / /\_\_\_\_\_\_

Residential Street Address: Apt#:

City: State: Zip: Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address if different from above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Email:

**Emergency Contact Person Information**

Name: Relationship:

Phone (daytime): Phone (evening):

If this application has been completed by someone other than the Applicant, please complete the following:

Name: Phone Number:

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following questions are to help us determine your eligibility.

1. What is your current mode of transportation? Please check all that apply to you.

 \_\_\_\_Walk/Ride Mobility Device \_\_\_\_ Bicycle

 \_\_\_\_ Drive a vehicle \_\_\_\_ Ride in someone’s vehicle

 \_\_\_\_ Taxi/Rideshare \_\_\_\_ Other

1. Are you able to use the Votran Fixed Route System now? \_\_\_\_Yes \_\_\_\_ No
2. Could you use the bus system if you could get to a stop? \_\_\_\_Yes \_\_\_\_ No

If no, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Based on where you live, where is the closest bus stop available to you? (To view the bus stops on the Route please visit our website at ([www.votran.org](http://www.votran.org))

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1. In other places you may have lived, did you use their public bus, or train system?

\_\_\_\_ Yes \_\_\_\_ No

If yes, how long ago and how frequently did/do you use that system?

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

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1. Please explain why you currently can or cannot use the Votran Fixed Route system.

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1. Is your condition: \_\_\_\_ Temporary \_\_\_\_ Permanent
2. When did your condition begin?

 \_\_\_\_0-1 year ago \_\_\_\_ 1-5 years ago

 \_\_\_\_ longer than 5 years \_\_\_\_ Birth

1. Does your condition require use of the following (please select all that apply)

 \_\_\_\_Support Cane \_\_\_\_ Wheelchair (manual)

 \_\_\_\_ White Cane \_\_\_\_ Wheelchair (reclining)

 \_\_\_\_ Walker (collapsible) \_\_\_\_ Power Chair

 \_\_\_\_ Walker (with seat) \_\_\_\_ Scooter

 \_\_\_\_Crutches \_\_\_\_ Leg Brace(s)

 \_\_\_\_ Prosthesis \_\_\_\_ Charcot Boot

 \_\_\_\_ Leg Brace(s) \_\_\_\_ Hearing Aide(s)

 \_\_\_\_ Portable Oxygen Device \_\_\_\_ Other Device

 Please describe “Other Device” if selected: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Does your condition require you to travel with portable medical equipment?

\_\_\_\_ Yes \_\_\_\_ No

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Are you able to walk with a mobility device?

 \_\_\_\_ Yes \_\_\_\_ No

1. Please indicate which of the following you are able to do on your own or with the help of a mobility device (please check all that apply)

 \_\_\_\_ Get in and out of a vehicle

 \_\_\_\_ Get on or off a vehicle

 \_\_\_\_ Understand bus schedules

 \_\_\_\_ Grasp handles to get on or off a vehicle using steps, ramp or a lift

 \_\_\_\_ Step up and down on a curb

 \_\_\_\_ Get up or down 3 or 4 stairs

1. How far can you go on level ground with the use of your mobility aide, if you use any?

 \_\_\_\_1-2 blocks \_\_\_\_ 3 or more blocks

 \_\_\_\_ Less than 1 block \_\_\_\_ Unknown

1. Can you climb and descend steps on a Fixed Route Bus?

 \_\_\_\_ Yes \_\_\_\_ No

1. Please tell us about any barriers that may prevent you from using Votran and whether those barriers are temporary or permanent. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Functional abilities using the Fixed Route Buses (check all that apply)

\_\_\_\_ I can get to and from a bus stop if the distance is not too far.

\_\_\_\_ My ability to use the Fixed Route Bus System can change from day to day.

\_\_\_\_ I can get to and from bus stops only if there are curb ramps and level

 sidewalks.

\_\_\_\_ I have difficulty understanding or remembering all the things to use a Fixed

 Route Bus System.

\_\_\_\_I have difficulty recalling information needed to travel alone.

1. Does your condition require you to travel with a Service Animal? (Emotional support or comfort animals are not considered service animals under the ADA.)

 \_\_\_\_Yes \_\_\_\_ No \_\_\_\_ Sometimes

1. If sometimes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What is your service animal trained to do for you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Does your condition require you to travel with a Personal Care Attendant (PCA)?

\_\_\_\_Yes \_\_\_\_ No \_\_\_\_ Sometimes

If yes or sometimes, please explain:

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

1. If your condition prevents you from using the Votran Fixed Route Bus System, can it be verified in writing by a Healthcare Professional (see verification form for list of approved persons who can fill it out)

 \_\_\_\_ Yes \_\_\_\_ No

1. Do you have Medicaid? Yes \_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_

 If yes what is your 10-digit Medicaid number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Certification of Applicant**

I,

(print name)

## certify that the information contained in this application is true and complete to the best of my knowledge. The purpose of this application is to determine if I am eligible to use ADA Paratransit Services, or if at times I can ride the Votran Fixed Route Bus. I understand that any falsification of information on this form may lead to disqualification of eligibility.

Signature Date

# END OF APPLICATION

**To the Applicant:**

Please have this form completed by a professional before sending your application to Votran. Any one of the following professionals listed below may fill out and sign this Professional Verification form:

Authorization Release to Be Completed by the Applicant

I, authorize the professional completing the

(Printed Name of Applicant)

Professional Verification Form to release to Votran any protected health information about my disability/health condition in order to verify of my eligibility for ADA Paratransit service.

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

**To the Professional:** Please check your professional title

 \_\_\_\_Physician \_\_\_\_ Physician Assistant

 \_\_\_\_ Psychiatrist \_\_\_\_ Mobility Specialist

 \_\_\_\_ Chiropractor \_\_\_\_ Registered Nurse

 \_\_\_\_ Physical Therapist Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Greetings,

This is the Professional Verification Form for Votran Transit ADA Paratransit. The ADA regulations state that persons are eligible for ADA Paratransit service, if their pick-up and drop-off points are in the ¾ mile buffer zone and have a condition that prevents them from independently using Votran’s Fixed Route Bus Service. ADA Paratransit eligibility is not based on the person’s lack of knowledge of the bus service, distance from bus service, ability to drive, language ability, or age. The information you provide will assist in determining under what circumstances this applicant may be eligible for Votran ADA Paratransit Service.

1. Applicant’s Name:
2. Applicant’s DOB:
3. Capacity in which you know the applicant:
4. Last date of face-to-face contact with this applicant was on:
5. Please describe the condition that may prevent the applicant from independently using the Votran Fixed Route Bus system:
6. Would the condition prevent the applicant from using the Votran Fixed Route Bus Route some or all the time? Please Explain.
7. Is the applicant’s condition:

\_\_\_\_\_ Temporary

\_\_\_\_\_ Permanent

1. If temporary how long would you anticipate the condition lasting? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Does the applicant have the mental capacity, visual, and/or hearing ability to:

* + Ask for, understand, and follow directions? \_\_\_\_\_ Yes \_\_\_\_\_ No
	+ Safely/Effectively transfer to another bus if needed? \_\_\_\_\_ Yes \_\_\_\_\_ No
	+ Are there any other mobility concerns of which Votran should be aware? If so please explain:

#### Can the applicant complete the following on their own or with the aid of a mobility device?

* + Travel less than a block (approx. 200ft)? \_\_\_\_\_ Yes \_\_\_\_\_ No
	+ Step up on to and off a curb? \_\_\_\_\_ Yes \_\_\_\_\_ No

* + Grip a hand rail? \_\_\_\_\_ Yes \_\_\_\_\_ No

1. Does the applicant use a mobility device(s)? Please check all that apply.

 \_\_\_\_Support Cane \_\_\_\_ Wheelchair (manual)

 \_\_\_\_ White Cane \_\_\_\_ Wheelchair (reclining)

 \_\_\_\_ Walker (collapsible) \_\_\_\_ Power Chair

 \_\_\_\_ Walker (with seat) \_\_\_\_ Scooter

 \_\_\_\_Crutches \_\_\_\_ Leg Brace(s)

 \_\_\_\_ Prosthesis \_\_\_\_ Charcot Boot

 \_\_\_\_ Leg Brace(s) \_\_\_\_ Hearing Aide(s)

 \_\_\_\_ Portable Oxygen Device \_\_\_\_ Other Device

 Please describe “Other Device” if selected:

1. Does the applicant require a Personal Care Attendant (PCA) to travel? Please explain:
2. Are there any other comments you would like to include about the applicant in regard to their condition?

*I, certify under penalty of perjury that the information contained in this form is true and correct.*

Name: Position/Title:

Signature: Date: / /

Name of Organization/Office:

Address:

Phone: Email:

#### Instructions for Submitting This Form:

If the applicant requests you return this form to them, please return it to the applicant.in an official sealed envelope. You may also submit the form via the following methods:

**Mail: Attn: Eligibility Department**

Votran 950 Big Tree Road, South Daytona,

FL 32119

**Fax: Eligibility Department**

(386) 322-5119