In order to be eligible to use CTP's Paratransit service as an ADA eligible rider, your disability must prevent you from using the existing accessible fixed route bus service. In accordance with the *"Americans with Disabilities Act of 1990"* (ADA), there are three specific circumstances under which a person would be considered ADA eligible for Paratransit service:

1. The individual is unable, as a result of physical, visual or mental impairment, and without the assistance of another individual (other than the driver of the bus) to board, ride or disembark from any vehicle in the fixed route system, which is accessible to individuals with disabilities.
2. The individual with a disability could utilize an accessible vehicle but such a vehicle does not operate on the fixed route he/she wishes to travel.
3. The individual with a disability has a specific impairment related condition, which prevents travel to a boarding location or from a disembarking location on the fixed route system.

Disability, age and/or distance to and from a bus stop **DO NOT**, by themselves, qualify a person for paratransit. Inconvenience and/or decreased comfort **ARE NOT** a basis for qualification. The condition must **PREVENT** travel by fixed route bus. Please keep in mind; all fixed route buses are equipped with wheelchair lifts or ramps, along with securement devices. Whenever possible, fixed route buses are to be utilized.

The information you provide will assist us in making an appropriate determination. Our evaluation is a transportation decision, not a medical decision. All information will be kept confidential. All questions must be answered in full or the application will be considered incomplete. An incomplete application will be returned to the applicant one time. If it is submitted a second time and is still incomplete, it will be held for 60 calendar days before it is discarded. Faxed copies will not be accepted. CTP may retain the services of a registered occupational therapist or a registered physical therapist if consultation about a disability is thought necessary.

Please type or print clearly.

Once the completed application and professional verification has been received, a determination of your eligibility will be made within 21 calendar days. You will be notified of your eligibility by mail. Any fees charged for the completion of certification forms are not the responsibility of the Cheyenne Transit Program. Eligibility will be valid for at least 90 calendar days (depending on eligibility criterion) and recertification is required every 3 years. If deemed qualified, you will be issued an ID card that MUST be shown upon boarding a paratransit bus. Arrangements will be made at a later date to issue your ID card. If you are dissatisfied with your eligibility determination, you may appeal within sixty days of the date of the letter notifying you of your eligibility status.

In order to be eligible for this service, you must reside within 3/4 of a mile of our fixed route corridor and the time of your trip must fall within the hours of the closest CTP bus route. If you do not reside within the 3/4 radius, you must have a means of getting within our service area before transportation is provided.

This document is available in large print and Spanish upon request.

CHEYENNE TRANSIT PROGRAM
322 WEST LINCOLNWAY
CHEYENNE, WY 82001
(307) 637-6253

1. INFORMATION

Name _____ ☐ Female ☐ Male
First Middle Initial Last

Home address: _____Apt #: _____

City/State: _____Zip:_____

Mailing address: _____Apt #: _____

City: _____Zip: _____

Telephone: (_____) _____ Date of Birth: _____/_____/_____

Please provide the name of a LOCAL friend or relative to call in the event of an emergency:

Name _____ ☐ Female ☐ Male
First Middle Initial Last

Home address: _____Apt #: _____

City/State: _____Zip:_____

Telephone: (_____) _____ Relationship:_____

Do you <u>need</u> information given to you in any of the following formats:

☐ Large Print ☐ Audio Tape ☐ Braille ☐ Computer Disk ☐ None

II. PRESENT MEANS OF TRAVEL

1. Do you currently use Public Transportation (City Bus)? ☐ Yes ☐ No
2. Have you ever ridden on a Cheyenne Transit Fixed Route (CTP) Bus? ☐ Yes ☐ No
   A. If yes, when was the last time you rode a CTP Fixed Route Bus (select one)?
      ☐ Last 3 months ☐ Last 6 months ☐ Last 12 months ☐ Last 2 years
      ☐ Last 5 years ☐ More than 5 years ☐ I've never ridden a bus
3. Have you ridden other public transportation (city bus) regularly in another city? ☐ Yes ☐ No
   A. If yes, when was the last time you rode a city bus?
      ☐ Last 3 months ☐ Last 6 months ☐ Last 12 months ☐ Last 2 years
      ☐ Last 5 years ☐ More than 5 years ☐ I've never ridden a city bus

Official Use Only	COMPLETE app received:_____ ☐ Eligible ☐ Temporary
	Returned to applicant to complete:_____ ☐ Ineligible ☐ Permanent
	Notification sent to applicant:_____ Appointment for ID Issue:_____
	ID #_____ Expires:_____

II. PRESENT MEANS OF TRAVEL CONTINUED …

4. How far from your home is the nearest CTP public bus stop?

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

5. Have you ever received travel training on how to use public transportation (city bus) service?

☐ Yes ☐ No

6. Are you aware that persons with disabilities can ride the CTP route bus for half-fare? (must apply)

☐ Yes ☐ No *The half bus fares are as follows: One Ride =. 50 cents*

7. How do you currently travel to your most frequent destinations? (Check all that apply)

☐ Route Bus ☐ Paratransit ☐ Friend/Relative drives vehicle
☐ Walk ☐ School Bus ☐ Private Taxi, car or Van
☐ Drive myself ☐ Other, Please Explain: _____

Please list your three most frequent trips and how you get there now:

A. Destination:_____

Times per week:_____Get there by:_____

B. Destination:_____

Times per week:_____Get there by:_____

C. Destination:_____

Times per week:_____Get there by:_____

III. ANALYSIS OF APPLICANT NEEDS AND ABILITIES

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

☐ Less than 1 block ☐ 1 block ☐ 2 blocks
☐ ¼ mile (3 blocks) ☐ ½ mile (6 blocks) ☐ ¾ mile (9 blocks)

9. Please identify the type of disability or health related condition(s):

☐ Visual Is this condition? ☐ Permanent ☐ Temporary ☐ Don't Know
☐ Cognitive Is this condition? ☐ Permanent ☐ Temporary ☐ Don't Know
☐ Mobility Is this condition? ☐ Permanent ☐ Temporary ☐ Don't Know

10. What disability or health related condition **prevents** you from using the route bus? _____

➢ How does it **prevent** you from using the route bus?_____
_____

ANALYSIS OF APPLICANT NEEDS AND ABILITIES CONTINUED …

11. WITHOUT the help of someone else, can you…

A. Ask for and understand written or spoken instructions?
☐ Always ☐ Sometimes ☐ Never ☐ Not Sure

B. Cross the street?
☐ Always ☐ Sometimes ☐ Never ☐ Not Sure

C. Step on and off a sidewalk from the curb?
☐ Always ☐ Sometimes ☐ Never ☐ Not Sure

D. Find your own way to the bus stop if someone shows you the way once?
☐ Always ☐ Sometimes ☐ Never ☐ Not Sure

E. Walk up and down three steps if there is a handrail?
☐ Always ☐ Sometimes ☐ Never ☐ Not Sure

F. Walk up and down a flight of stairs if there is a handrail?
☐ Always ☐ Sometimes ☐ Never ☐ Not Sure

G. Capable of getting around in a store or shopping mall by yourself?
☐ Always ☐ Sometimes ☐ Never ☐ Not Sure

H. Wait outside without assistance or support for fifteen minutes?
☐ Always ☐ Sometimes ☐ Never ☐ Not Sure

12. Do you travel with a Personal Care Attendant? ☐ Yes ☐ No

13. Do you use any mobility aids or specialized equipment?

☐ Cane ☐ Power Chair** ☐ Manual Chair** ☐ Power Scooter (3 or 4 wheel)*

☐ White Cane ☐ Walker ☐ Speech Devices ☐ Portable Oxygen Tank

☐ Crutches ☐ Leg Braces ☐ Communication Board

☐ Respirator ☐ Prosthesis ☐ Personal Care Attendant

☐ Service Animal* ☐ Other _____

*What type of animal? _____

What task(s) does the service animal provide?

_____

**Please Note: In accordance with the ADA, CTP vehicles are designed to accommodate mobility devices that weigh no more than six hundred pounds when occupied. If your mobility device exceeds these specifications, we may still be able to transport you. Please call CTP for an evaluation to determine whether we can accommodate your mobility device.

How wide is your mobility device? _____inches How long is it? _____inches

How much does your mobility device weigh when in use? _____pounds

Is there anything else you want to tell us about your disability or health condition that might help us better understand your travel abilities and limitations? _____

_____

_____

_____

_____

IV. APPLICANT SIGNATURE

I certify that the information I gave in the application is true and correct. I understand that falsification of information may result in denial of service. I understand all information will be kept confidential; only the information required to provide services I request will be disclosed to those who perform those services. The application will not be processed without application signature.

_____ Date: _____
Applicant Signature

_____
Applicant Name (Please print)

V. PERSON OTHER THAN APPLICANT COMPLETING FORM

Please check one of the items below:

☐ I certify that the information provided in this application is true and correct based upon information given to me by the applicant.

☐ I certify that the information provided in this application is true and correct, based upon my own knowledge of the applicant's health condition or disability.

Signature _____ Date: _____

Print Name _____ Daytime Phone number: _____

Address: _____

_____

Relationship to Applicant: _____

VI. AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(to be completed by applicant)

I hereby authorize the following licensed professional (doctor, therapist, social worker, etc.), who can verify my disability or health-related condition, to release this information to the Cheyenne Transit Program eligibility certification staff or a contractor working for the agency to conduct eligibility screenings. This information will be used only to verify my eligibility for ADA paratransit services. I understand that I have the right to request and receive a copy of this authorization, and that I may revoke it at any time.

Name of Medical Professional who may release my medical information:

_____
Name of Medical Professional

_____
Address of Medical Professional

_____
City, State and Zip Code

_____
Telephone Number of Medical Professional

_____
Fax Number of Medical Professional

_____
Medical Record or Identification number, if known

Applicant Name (Please Print) _____

Applicant Signature:_____Date: _____

Please return this form and the following completed form to:

Cheyenne Transit Program
322 West Lincolnway
Cheyenne, WY 82001
(307) 637-6253

The following portion of the application must be completed and signed by a

currently licensed health care professional.

VII. PROFESSIONAL VERIFICATION

The individual who has asked you to review and sign this application is applying to the Cheyenne Transit Program to be considered eligible for paratransit service. **ADA paratransit service is intended ONLY for those trips that the person cannot take on the regular public bus fixed route system due to his/her physical or mental disability**.

Please note that all regular public route buses are equipped with wheelchair lifts.

•What disability **prevents** the applicant from riding the regular public route bus system?

- Please explain in DETAIL the applicant's physical, developmental, cognitive or visual disability/disabilities, including the applicant's prognosis.

_____

_____

- How does it **prevent** travel on ADA accessible fixed route buses?

_____

_____

- If disability is cognitive or developmental, please supply information regarding the applicant's functional abilities and any recent evaluations. All information will be kept confidential.

_____

_____

•Is this condition temporary: ☐Yes ☐ No If yes, expected duration:_____

Exceptions or additions: _____

_____

•How far can applicant walk or travel with use of mobility device :

☐ Less than 1 block ☐ 1 block ☐ 2 blocks

☐ ¼ mile (3 blocks) ☐ ½ mile (6 blocks) ☐ ¾ mile (9 blocks)

Additional Information:_____

_____

I certify that the information contained in this application is true and correct to the best of my knowledge and ability.

Signature_____ Date: _____

Print Name _____

Daytime Phone number: _____Agency/Clinic:_____

Address:_____

Professional License, Registration or Certification #:_____Expires:_____