133 V Street, Eureka, Ca. 95501
Main Office: 707-443-0826
Fax: 707-443-2032

Dial-a-Ride ADA Paratransit Service

Dial-A-Ride ADA Paratransit is transportation for persons, who because of a physical or mental condition are unable to ride public fixed-route transportation. In order to be determined eligible under one of the following categories as defined by the U.S. Department of Transportation and the U.S department of Justice the following categories will determine your eligibility.

Category 1

Individual cannot independently use accessible fixed route transit due to a disability either some or all of the time. [Section 37.123(e)(1) of the ADA regulations]

Category 2

The fixed route vehicles the passenger needs to use are not accessible and/or the lift cannot be deployed at needed stops. [Section 37.123(e)(2) of the ADA regulations]

Category 3

Individual's specific impairment related condition prevents him/her from getting to or from the fixed route transit system. [Section 37.123(e)(3) of the ADA regulations]

The Humboldt Transit Authority reserves the right to conduct a re-certification process as necessary to keep our records up-to-date. Service will be provided only to persons who have been certified. Qualified Medical Professionals will be asked to assist in making the determination of certification by completing a form describing the applicant's disability. The final decision as to whether or not the applicant qualifies for Dial-a-Ride will be made by Humboldt Transit Authority.

To help us accurately determine your eligibility for Dial-a-Ride, please fill out the application form as completely and thoroughly as possible. Once you have completed the form the Humboldt Transit Authority will determine if it will be necessary for a phone interview or an in-person interview.

Interview and Application Process

If we find that additional information is required to process your application, or if your application is incomplete, we will contact you to conduct a phone interview or schedule an in-person interview. During the interview, we will ask you further questions about your eligibility to better assess your travel abilities and limitations.

If you are determined eligible for Dial-a-Ride for some trips or for all trips, we will notify you by phone or in writing. The decision will be made within 21 days of the date you complete your interview or assessment. If a decision is not made within 21 days, we will provide you with dial-a-ride until a final decision is made. This does not apply if we are unable to complete the processing of an incomplete application.

For complaints, comments or eligibility about the system please contact Humboldt Transit Authority,- Cody Ferreira, at 707-443-0826 ext.104. All information will be confidential

Application Instructions

1. Please PRINT OR TYPE full responses to all questions on the application form. Your detailed responses and explanations will help us make an appropriate determination. Be sure to respond to ALL questions or your application will be considered incomplete. Incomplete applications will be returned.

2. Complete the information on the applications in sections 1 and 2

3. Section 3 must be filled out by a Licensed Healthcare Professional

4. You must provide SIGNATURES in 3 places to have a completed applications
   - Page 7 Certification and Authorization
   - Page 8 Notice of Privacy Act
   - Page 9 Authorization to Release Information for an appropriate medical or rehabilitation professional

5. Return the completed application to:

Humboldt Transit Authority
133 V Street
Eureka, Ca. 95501
*******OR*******
Fax to: 1-707-443-2032

For Help with the application process or to check the statue of your application Call 707-443-0826 ext.104

Application For Dial-A-Ride ADA Paratransit Service

Please Print

Date:____/____/_____

Client#_____
Approved ☐
Recert ☐
Declined ☐
****For internal use only****

Section 1: Applicant Information

First Name:_____ MI:___ Last Name:_____
Home Adress:_____ City:_____ Zip Code:_____
Mailing Address:_____ City:_____ Zip Code:_____
(if different from your home address)
Date of Birth:____/____/_____ Age:_____ Gender:_____
Email address (optional):_____
Home Phone:(____)_____-_____ Mobile Phone (optional):(_____)_____-_____

#1 Emergency Contact Name:_____ Phone:_____
#2 Emergency Contact Name:_____ Phone:_____

What is your disability/medical diagnosis that prevents you from using Public Transit?
No longer driving is NOT a limitation

_____
_____
_____

Has you disability/medical diagnosis been verified by a doctor? Yes_____ No____
Is this condition temporary? Yes_____ No_____
If yes, please list the date you expect the temporary condition will no longer exist:____/____/_____

Do you have a communication disability which necessitates the use of some type of communications aid?
Yes_____ No_____
If yes, what kind of communication aid do you require?

_____
_____
_____

If accepted to use Dial-a-Ride, will you require the assistance of an attendant?
Yes_____ No_____

If yes, please name the attendant:_____
Attendant Phone Number:(____)_____-_____

Section 2: Current Mobility Information

If you require the use of mobility aids, please check all that apply:

- ☐ Walker
- ☐ Manual Wheelchair
- ☐ Service Animal
- ☐ No Mobility aids
- ☐ Manual Wheelchair
- ☐ Cane
- ☐ Oxygen
- ☐ Other_____
- ☐ Crutches
- ☐ Electric Wheelchair
- ☐ Power Scooter (3 wheels)

If you use any mobility aids, what types of obstacles could prevent you from using the public transit system that are equipped with ramps or lifts?

_____

_____

_____

Do you currently or have you ever road the public transit fixed route service?

Yes_____ No_____ Sometimes_____

If no, how do you currently travel?_____

If Yes, how frequently do you ride the fixed route system?

Daily_____Monthly_____ Weekly_____ Monthly_____

How far do you live from the nearest bus stop?

- ☐ Less than 1 block
- ☐ 1-3 blocks
- ☐ 3-6 blocks
- ☐ 6 or more

Are there any environmental conditions that prevent you from using the fixed route system?

_____

_____

_____

Can you wait outside without support for 10 minutes?

Yes_____ No_____

Can you access the bus using the ramp or lift?

Yes_____ No_____

Does your disability change from time to time due to medical treatments, medications or other reasons?

Yes_____ No_____

If yes, please explain: _____

_____

How did you hear about Dial-a-Ride Program?

Outreach Event/Resource_____ Family/Friend_____ Social worker/Case Manager_____

Online____ Doctor_____ Other_____

Section 3: Healthcare Professional Verification - Required for all Dial-a-Ride applicants

***** This verification form must be completed by a qualified licensed healthcare professional. Examples include but are not limited to a physician, psychiatrist, psychologist, chiropractor, ophthalmologist, physical therapist, registered nurse.*****

Name of Professional_____License No._____
Title_____ Agency/Affiliation_____
Business Address_____
Business Telephone(_____)_____

Name of client:_____

Medical diagnosis that causes the client's Disability_____
Is this temporary? _____Yes (Expected duration:_____) _____No , its permanent
Does the applicant's disability require they travel with an attendant? Yes_____ No_____ Sometimes_____
Explain "Yes" or "Sometimes" _____

If the client has a disability affecting mobility or is legally blind, are they able to:

	Yes	No	Sometimes
Travel a distance of 200 feet without assistance?	☐	☐	☐
Travel a distance of 3 blocks(1/4 mile) without assistance?	☐	☐	☐
Travel a distance of 6 blocks (1/2 Mile) without assistance?	☐	☐	☐
Wait outside without support for 10-20minutes in different weather conditions?	☐	☐	☐
Cross a 2-way stop?	☐	☐	☐
Cross a 4-way stop?	☐	☐	☐
Cross traffic light-controlled intersections?	☐	☐	☐

Explain "No" or "Sometimes" responses:

_____
_____
_____

If the client has a cognitive disability, are able to:

	Yes	No	Sometimes
Give their name, address, and telephone numbers upon request?	☐	☐	☐
Recognize a destination or landmark?	☐	☐	☐
Deal with unexpected situations or unexpected changes in routine?	☐	☐	☐
Ask for, understand, and follow directions?	☐	☐	☐
Safely and effectively travel through crowded and/or complex facilities?	☐	☐	☐

Explain "No" or"sometimes" responses:

_____
_____
_____

Section 3 Continued

If the client is speech impaired, are they able to:

	Yes	No	Sometimes
Communicate verbally?	☐	☐	☐
Communicate with augmentative device?	☐	☐	☐
Communicate in writing?	☐	☐	☐
Communicate over the phone?	☐	☐	☐

Explain "No" or "Sometimes" responses:

_____

_____

_____

I verify that the information on this verification form of eligibility form is true and correct to the best of my knowledge.

Signature of Qualified Healthcare Professional_____

Date_____

General Healthcare Provider Information

In order for the Humboldt Transit Authority to evaluate and finalize your request, we need your health care or rehabilitation professional information below. It is important that you identify one or more qualified professionals who are familiar with your particular disability and how it prevents you from using the fixed route bus system. You must include complete telephone and address information including zip codes for all professionals listed.

Family Physician (or another qualified professional)

Agency Phone Number

Address

City Zip code

Family Physician (or another qualified professional)

Agency Phone Number

Address

City Zip code

Certification and Authorization:

I certify that the information provided in this application is true and correct. I understand that falsification of information may result in denial of service. I authorize the professionals listed above release to Humboldt Transit Authority information about my disability and its effects on my ability to travel on fixed route bus system. I understand that I may revoke this authorization at any time.

Signature of Applicant:_____ Date:_____/_____/_____

Signature of person assisting Applicant:_____

Relationship:_____

Print Name:_____

Notice of Privacy Practice

Humboldt Transit Authority respects your privacy. We understand that your personal health and eligibility information is sensitive. We will not disclose your information to anyone outside of the agency unless you in writing, or unless the law authorizes us to do so. Also, we cannot process any eligibility application that does not have authorization signed by you, your representative or legal guardian on all pages where a signature is required. Our privacy practices cover all authorized information contained in your ADA eligibility file.

Use and Disclosure of ADA Eligibility Information

The information contained in your eligibility file includes all applications submitted and any health information received that aids in the determination of your eligibility. It may also include any letters received on your behalf, documented conversations, trip plans, and other information pertinent to your ADA eligibility and service provision.

The Humboldt Transit Authority uses this information to determine eligibility and for assessing or providing transportation service needs. Staff access to this information is limited to those employees who must review it for the purposes stated above. Conditional and temporary paper applications and eligibility determination information will be kept for 1 year. Unconditional applications will be kept for 5 years and all eligible applicants will be required to submit a new re-certification process. Certifications may be reviewed if someone questions your eligibility determination or may be reviewed in a FTA Compliance Review.

- You have the right to review your file. Your request must be made in writing or review mat occur in person with valid identification.
- You may request that a copy of your file be mailed to you. you may be required to pay a fee for this service.

Received and Reviewed:

Please Print Name:_____

Circle one:

Applicant / Patient / Responsible Party Signature:_____

Relationship to Applicant/Patient:_____ Date:_____/_____/_____

Medical Release Form for Humboldt Transit Authority

In order for Staff to process your transportation application and obtain needed medical Information to make eligibility determination, we must ask that you complete and sign this information release form. This release form authorizes the release of medical information that is needed to determine eligibility for door to door service. Failure to complete this form may result in the delay of eligibility determination or denial of service.

I_____authorize Humboldt Transit Authority, to review my personal medical records submitted by a qualified professional. I understand that this information will be used solely for the purpose of determining eligibility for transportation services and will not be shared with any other agencies except where allowed by law. I understand I have the right to revoke this authorization in writing at any time. I understand that failure to provide authorization may result in the denial of transportation services until such time that the information being requested may be obtained.

Received and Reviewed:

Print Name:_____

Circle one:
Applicant / Patient / Responsible Party Signature:_____

Relationship to Applicant / Patient:_____ Date:____/____/_____