



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 Address: _____ 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 your 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:

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> Walker | <input type="checkbox"/> Crutches | |
| <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Cane | <input type="checkbox"/> Electric Wheelchair |
| <input type="checkbox"/> Service Animal | <input type="checkbox"/> Oxygen | <input type="checkbox"/> Power Scooter (3 wheels) |
| <input type="checkbox"/> No Mobility aids | <input type="checkbox"/> Other _____ | |

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 rode 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Travel a distance of 3 blocks(1/4 mile) without assistance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Travel a distance of 6 blocks (1/2 Mile) without assistance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wait outside without support for 10-20minutes in different weather conditions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cross a 2-way stop?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cross a 4-way stop?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cross traffic light-controlled intersections?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recognize a destination or landmark?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deal with unexpected situations or unexpected changes in routine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ask for, understand, and follow directions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safely and effectively travel through crowded and/or complex facilities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explain "No" or "sometimes" responses:

Section 3 Continued

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

	Yes	No	Sometimes
Communicate verbally?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicate with augmentative device?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicate in writing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicate over the phone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)

Family Physician (or another qualified professional)

Agency Phone Number

Agency Phone Number

Address

Address

City

Zip code

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 may 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: ____/____/____