ADA Paratransit Eligibility

Round Rock Paratransit Service is for individuals with a disability which prevents them from independently traveling on the fixed route service either all of the time or some of the time. The Americans with Disabilities Act (ADA) outlines specific criteria to determine eligibility for paratransit services; therefore, an application and an in-person eligibility interview are required to determine an applicant's individual eligibility.

To apply for this service, you and your healthcare professional must complete this application. Other supportive documentation may be included with your application. The information you provide may be shared with other transit providers to facilitate your travel in other areas.

If you need any type of alternative format for this application or have any questions, contact (512) 218-7074.

Please read and follow these instructions.

Part A: Applicant Information & Release – You Complete

Part B: Healthcare Provider Verification – Healthcare Professional Completes
See below who is authorized
The applicant MAY NOT complete this section.

It is very important, for you and your healthcare provider, to thoroughly answer each question on the application.

Once *ALL* paperwork is complete, you may either:

Mail to or deliver in person to:
City of Round Rock
ATTN: Transit Coordinator
300 W. Bagdad
Round Rock, Texas 78664

Email to: ejohnson@roundrocktexas.gov

All information received in this application will be kept **CONFIDENTIAL**

You will receive your eligibility determination within 21 calendar days from the date *ALL* of the following are completed:

- Original full application and verification received
- In-person interview
- Any additional requested information is received by staff
- Any applicant who has completed the above steps but has not received an eligibility determination letter, within 21 days, will be entitled to unlimited use of the paratransit service until you are notified your eligibility determination.

ADA Paratransit Eligibility

PART A: APPLICANT INFORMATION & RELEASE (please print)
All questions must be answered before your application will be considered.

PLEASE PRINT

Applicant's Name__________________________________Date of Birth______________________

Address____________________________________Apt # __________________________________

City______________________ State _____________________Zip _________________________

Email ____

Name of Apartment Complex or Nursing Home:____

Home Phone_______________________________Cell Phone ____________________________

Person to Contact in Case of Emergency

Name ______________________________________ Relationship__________________________

Home Phone ______________________________Cell Phone ______________________________

Do you require a Personal Care Attendant (PCA) to help you travel? ☐ Yes ☐ No

What disability have you been diagnosed with? ____

Is your disability or health conditional ☐ Permanent ☐ Temporary?

Temporary; expected to last until ______________________________________

Assistive Devices Used (Check All that Apply)

☐ Cane ☐ Manual Wheelchair ☐ Electric Conventional

☐ Crutches ☐ Portable Oxygen ☐ Walker

☐ Scooter ☐ Prosthesis ☐ Other __________________________

If using a wheelchair, does your residence have a wheelchair ramp for multiple steps? ☐ Yes ☐ No

If using a service animal, what service does the animal provide? ______________________________

ADA Paratransit Eligibility

Part A – Continued

Briefly explain how your disability prevents you from using the Fixed Route Buses (city buses) ________

____

Can you climb ten steps with a handrail, without assistance from another person? ☐ Yes ☐ No

If applicant has a disability affecting mobility, please indicate what distance, you are able to travel without the assistance of another person.

☐ less than 200 ft. ☐ 1 to 2 blocks ☐ 3 to 4 blocks

☐ 5 to 6 blocks ☐ 7 to 8 blocks ☐ 9 or more blocks

Describe your neighborhood: (check all that apply)

☐ sidewalks in front of your residence
☐ wheelchair ramps at your residence
☐ paved road in front of you
☐ unpaved road in front of your residence

CERTIFICATION

I certify all information contained in **PART A** of this application was completed by me or my authorized representative and is true and correct. I agree to notify the City of Round Rock of any changes in my status, which may affect my eligibility to use the service. I understand I will be required to attend an in-person eligibility review.

I have read and fully understand the conditions for service outlined in the ADA Complementary Paratransit Plan and agree to abide by them. I also understand failure to adhere to the policies and procedures will be grounds for revoking my application and the right to participate in the program. I agree that, if I am certified for Round Rock Paratransit Service, I will pay the exact fare, if required, for each trip.

I understand and agree to hold the City of Round Rock harmless against all claims or liability for damages to any person, property, or personal injury occurring as a result of my failure to equip or maintain the safety of the adaptive equipment or service animal I require for mobility.

I hereby authorize the release of verification information and any additional information to the City of Round Rock for the purpose of evaluating my eligibility to participate in the Program.

______________________________ ______________________________

Signature Date

Authorized Representative Information

Name______________________________Relationship to Applicant______________________________

______________________________ ______________________________

Signature Date

ADA Paratransit Eligibility

PART B: HEALTHCARE PROVIDER VERIFICATION (please print)
To be Completed by a Medical Professional Only

The applicant is asking you to review the information on this application and to complete and sign part B of this form certifying that they have a disability that prevents them from using Fixed Route buses (city buses). This information will be used to determine whether or not the applicant needs to use Paratransit service or is able to use Fixed Route service for their travel needs. ***To be completed by a medical professional who is knowledgeable about the applicant's functional ability.***

We need to know the limitation of their disability that limits their ability to ride the Fixed Route Bus the following is necessary for us to process this applications request:

- Through details of the applicants' functional limitations and how they inhibit that person's ability to board and use the Fixed Route Bus.
- Through details of the applicant's cognitive limitation and how they inhibit that person's ability to navigate using a Fixed Route bus.
- Through details of the applicant's physical limitation and how they inhibit that person's ability to reach a bus stop or the destination from a bus stop.

Under the Americans with Disability Act (ADA), if a person has the functional capability to use Round Rock city buses that person is not eligible for paratransit service (curb to curb). Disability alone and distance to and from a bus stop, by itself, does not qualify a person for Round Rock Transit paratransit service.

Thank you for our assistance. If you have any questions, please contact us 512-218-7074.

You are (Please check one):

☐ Medical Doctor (MD or DO) ☐ Optometrist ☐ Psychologist (Ph.D.)
☐ Physician Assistant ☐ Clinical Social Worker ☐ Chiropractor
☐ Nurse Practitioner ☐ Physical or Occupational Therapist
☐ Podiatrist ☐ Optometrist
☐ Other _______________

License/Certification ID #___________________________

ADA Paratransit Eligibility

Part B – Continued

Name of Patient/Applicant ____________________________________ Last Seen ______________

Please describe the medical diagnosis, physical or cognitive disability ________________________
____

If curb to curb service is needed, please describe the physical and/or cognitive condition and how it functionally prevents the applicant form using regular city buses: ____________________________
____
____

Is the disability permanent or temporary? ☐ Temporary ☐ Permanent

Are any of the applicant's conditions episodic or variable in their severity? Some examples would include fatigue from dialysis or relapsing and remitting systems as in MS?

☐ No ☐ Yes If yes please provide details: ____
____
____

CERTIFICATION

Person Completing Form:____

Professional Title____

Agency Affiliation____

Business Address______________________________________City______________Zip________________

Phone ____

I certify the information contained in **Part B** is true and correct to the best of my knowledge. I hereby verify the diagnosis of disability listed has been reviewed by me, is accurate and true, and represents the current condition of the applicant named in this application.

_____________________________________ _________________________
Signature Date