



CITY OF ESCALON

Dear Passenger,

Thank you for your interest in eTrans. This service is available to persons that meet the requirements of the Americans with Disabilities Act (ADA) that cannot ride fixed route transit because of your disability. The ADA is a law, which requires accessible transportation for persons with disabilities, which closely matches the service offered by eTrans. This application will ask questions about your ability to access eTrans and its facilities.

The ADA was created to assure that all persons with disabilities, who are unable to use the regular fixed route bus service or access fixed route bus stops, have complementary transportation to the regular fixed route bus service. This means that a person who is unable to use the regular bus should be able to travel on the same days, during the same hours, and in the same general area as the fixed route bus travels (within a $\frac{3}{4}$ of a mile corridor), for a fare, which is not more than twice the one way adult fare of a fixed route bus ride. eTrans is designed to meet these requirements.

According to the ADA, each person who may qualify for paratransit **must** complete an eligibility application form. This form will help determine if you are eligible to use these services based on the definitions of the ADA. The eligibility process is related more closely to your functional ability to use the bus and requires you to answer the enclosed questionnaire very carefully. You are encouraged to have someone help you with the questionnaire if you have questions.

An ADA ID Card with a registration number will be mailed to you within 21 days, if you are determined to be ADA eligible for ADA paratransit service. You will also be notified within 21 days, if you are determined to be ineligible for ADA paratransit service.

eTrans is also available to general public passengers. An application is not necessary for a passenger that does not have a disability. **For reservations and transit information, please call (209) 541-6645.**

If you have any questions about this application, or any part of the eligibility process, you may call me at (209) 321-1334 or 711 for TDD/TTY users through the California Relay Service.

Sincerely,

John Andoh
Transit Coordinator
City of Escalon

City of Escalon - Development Services Department
Planning – Building – Engineering - Transit
2060 McHenry Avenue, Escalon, CA 95320
Telephone: (209) 691-7400 Fax: (209) 691-7439

Please provide the name and phone number of a LOCAL friend or relative to contact in the event of an emergency:

Name _____ Relationship _____

Daytime Phone _____ Evening Phone _____

1. Do you use any of the following aids for mobility? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Electric Wheelchair |
| <input type="checkbox"/> Power Scooter | <input type="checkbox"/> Cane |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Oxygen Tank | <input type="checkbox"/> Service Animal |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> None |

2. Is your mobility device oversized? Yes No

a. If yes, please explain and advise weight: _____

Some buses may have weight restrictions on their wheelchair lifts. Please call your transit agency for more information.

3. Is your condition temporary? Yes No

If yes, expected duration: ___/___/___

4. Does your condition change from time to time due to medications, medical treatments, other? Yes No

If yes, please explain

Type of disability:

5. I have a **Visual** **Physical** **Mental** Impairment

6. **What** is your disability that prevents you from using the fixed route service?

7. **How** does your disability make it *impossible* for you to use the fixed route service?

8. How far can you continuously walk **OR** advance your manual wheelchair without the help of another person? (i.e., number of blocks) _____

Could you travel further if you stopped to rest?

- Yes No Sometimes

(If No or Sometimes, please explain why)

9. Have you ever used any of these transit services? Check all that apply:

Fixed Route Dial-A-Ride/Paratransit RTD Hopper Other _____

10. How many blocks from your residence is the nearest accessible bus stop?

Less than 1 Block 2 to 4 Blocks 4 or more Don't know

11. Can you independently get on and off a lift-equipped bus?

Yes No Sometimes Don't know

(If No or Sometimes, please explain why)

12. Is your ability to use public transit affected by weather or environmental/architectural barriers that block your path of travel? (e.g. temperature extremes, no sidewalks, lack of signal lights at a busy intersection, etc.)

Yes No (If Yes, please explain why)

13. Can you ask for, understand, and follow directions?

Yes No Sometimes

(If No or Sometimes, please explain why)

14. Can you cross a busy intersection?

Yes No Sometimes

(If No or Sometimes, please explain why)

15. If you are approved for Dial-A-Ride/Paratransit Services will you require a personal care attendant?

Yes No

Certification of Applicant

I hereby certify that, to the best of my knowledge, the information I have given in this application is correct and the application will be returned if it is not complete.

I understand that the results of the review will be based on my ability to use the fixed route system. Verification of my disability by my physician or health care professional, identified below, does not guarantee my eligibility for ADA certification of paratransit service.

Signature of Applicant _____

Date _____

If someone other than the applicant completed this application, the following information must be provided.

Name of person completing the application _____

Relation to the applicant _____

Daytime phone # _____

Please return this application once completed to the following locations where you live:

In Lodi: City of Lodi, Public Works Department, Transit Division, 221 Pine Street, Lodi, CA 95241

In Escalon: City of Escalon, Attn: Transit Coordinator, 2060 McHenry Avenue, Escalon, CA 95320

In Tracy: City of Tracy, Public Works Department, Tracy Transit Station, 50 East Sixth Street, Tracy, CA 95376

In Manteca: City of Manteca, Finance Department, 1001 West Center Street, Manteca, CA 95337

In Ripon: City of Ripon, Engineering Department, 259 North Wilma Street, Ripon, CA 95366

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize you to **release any information necessary to** determine **my eligibility** for ADA Paratransit service provided by the City of Escalon.

The City of Escalon has assured me that the requested information will be held in strictest confidence, and will be used only to determine my eligibility for paratransit service.

Identification of Physician or Health Care Professional

(Please type or print clearly)

Name and Title of Professional _____

Address _____,
(Number and Street) (City) (Zip Code)

Agency _____

Phone # _____ Fax # _____

Applicant Information

Date of Birth _____ SSN # (Last four) _____

Signature of Applicant _____ **Date** _____

Printed Name of Applicant _____

MEDICAL PROFESSIONAL VERIFICATION FORM

To process this application, the City of Escalon needs information about the effects of the applicant's disability on his/her **functional capability** to ride the regular fixed route bus service. This information is necessary to determine whether he/she is eligible for paratransit service under the regulations of the Americans with Disabilities Act (ADA).

The information you provide in this form will aid the City of Escalon in making an ADA eligibility determination. For the benefit of the applicant, please answer the questions as fully and accurately as possible. All information will be kept confidential.

The individual's condition must **prevent** travel on a fixed bus route, either all of the time, temporarily, or only under certain circumstances. Disability alone and distance to and from a bus stop do not, by themselves, qualify a person for paratransit service. **Inconvenience, decreased comfort, and/or pain are not a basis for qualification.**

(Please type or print clearly. Do NOT use ICD-9 or DSM codes.)

Applicant's Name _____

Capacity in which you know the applicant _____

Medical diagnosis _____

_____ Date of Onset _____

Prognosis _____

1. Does the applicant use any of the following aids for mobility?
(Check all that apply).

- | | |
|--|--|
| <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Electric Wheelchair |
| <input type="checkbox"/> Power Scooter | <input type="checkbox"/> Cane |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Personal Care Attendant | <input type="checkbox"/> Service Animal |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> None |

2. What category is the applicant's disability?

- Visual** **Physical** **Mental** Impairment

3. Applicant's Height _____ Weight _____

4. Is the applicant's condition temporary? ____ Yes ____ No

If Yes, expected duration: ____/ ____/ ____

5. Can the applicant wait outside without assistance for 15 minutes?

- Yes No

