

# Alameda County City-Based Paratransit Services Application Form

Please use this application if you are a resident of: *Alameda, Albany, Berkeley, Castro Valley, Emeryville, Fremont, Hayward, Newark, Oakland, Piedmont, Pleasanton, San Lorenzo, San Leandro or Sunol*. Upon receipt of this form, the program may contact you to submit additional information. ADA paratransit service operators (East Bay Paratransit, Union City Paratransit & Wheels Dial-A-Ride) require a separate application process. Please return this application to the paratransit program to which you are applying. For more information about specific programs, please refer to the Access Alameda brochure, [www.AccessAlameda.org](http://www.AccessAlameda.org), or call 1-866-901-7272.

**Name:** \_\_\_\_\_  
Last Name First Name Middle Initial

**Daytime Phone:** (\_\_\_\_) \_\_\_\_\_ **Evening Phone:** (\_\_\_\_) \_\_\_\_\_

**Cell:** (\_\_\_\_) \_\_\_\_\_ **TDD/TTY:** (\_\_\_\_) \_\_\_\_\_ **Email:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_  
Street Address Apt. # City Zip Code

**Name of Housing Facility** (if applicable): \_\_\_\_\_

**Birth Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Male**  **Female**   
Month Day Year

**Do you manage your own affairs and deal with your own mail?** Yes  No   
**If "No", to whom should important correspondence be mailed?**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Daytime phone:** (\_\_\_\_) \_\_\_\_\_ **Cell or Evening phone:** (\_\_\_\_) \_\_\_\_\_

**Email:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_  
(if different from above) Street Address or PO Box Apt. # City State Zip Code

**1. How do you currently travel to your most frequent destinations?** (Check all that apply)  
 ADA Paratransit (i.e. East Bay Paratransit, Wheels Dial-A-Ride, Union City Paratransit)  
 Drive myself  Someone drives me  Buses/BART  Taxi  
 Other: \_\_\_\_\_

**2. Have you been certified as eligible for rides with an ADA paratransit service?**  
**(i.e. East Bay Paratransit, Wheels Dial-A-Ride, Union City Paratransit)**  
 Fully eligible  Conditionally eligible **Rider Identification #:** \_\_\_\_\_  
 Not eligible/Denied  Have not applied  Don't know

**3. Do you use any of the following mobility aids or specialized equipment?**  
 Cane  White Cane  Walker  
 Manual Wheelchair  Power Wheelchair  Power Scooter  
 Service Animal  Portable Oxygen Tank  Other: \_\_\_\_\_

**4. Do you need a wheelchair lift to get in and out of a vehicle?**  Yes  No  Don't know

**5. Do you typically travel with assistance from another person** (other than driver)?  Yes  No

6. Please describe your disability or disabling health condition and explain how this condition prevents you from using public transit (i.e. buses or BART):

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7. Is the above condition you describe:  Permanent  Temporary until: \_\_\_\_\_

8. Emergency Contact Person: \_\_\_\_\_

Relationship to you: \_\_\_\_\_ Daytime phone: (\_\_\_\_) \_\_\_\_\_

Cell phone: (\_\_\_\_) \_\_\_\_\_ Evening phone: (\_\_\_\_) \_\_\_\_\_

9. Are you on any of the following forms of income/benefit assistance? (check all that apply)

- Supplemental Security Income (SSI)  Cash Assistance Program for Immigrants (CAPI)  
 Medi-Cal; if yes, #: \_\_\_\_\_  CalWorks  General Assistance (GA)

10. Gross Individual Monthly Income: \_\_\_\_\_

11. Gross Household Monthly Income: \_\_\_\_\_ # of people in household: \_\_\_\_\_

12. What is your living arrangement?  Live alone  Live w/ spouse/partner  
 Live with adult children  Live in a skilled nursing facility/nursing home  
 Live in assisted living/residential care home  Other: \_\_\_\_\_

13. What is your race/ethnicity?  African American  Asian/Pacific Islander  
 Caucasian  Hispanic/Latino  Native American  
 Other: \_\_\_\_\_

14. What language(s) do you speak? Preferred Language: \_\_\_\_\_  
Other Language(s): \_\_\_\_\_

15. If you need future information provided to you in an accessible format, please check which format you prefer:  Large Print  Audiotape  Braille  CD/Electronic File

*I certify that the information in this application is true and correct. I understand that knowingly falsifying information will result in denial of service. I give the City permission to contact me about my paratransit service experience and to verify my enrollment with East Bay Paratransit, Wheels Dial-A-Ride or Union City Paratransit. I understand that my application information will be kept confidential; only information required to provide service or verify service quality will be disclosed under any circumstances.*

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Person who assisted you with application/Phone #: \_\_\_\_\_

# Alameda County City-Based Paratransit Services Medical Statement Form

This form must be completed if the applicant **does not meet the "Senior" age eligibility requirement** (see pages 2 & 3 of application cover sheet) of the city-operated paratransit service for which he/she is applying. For more information, please call your city's paratransit program or 1-866-901-7272.

Applicant's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_

### Dear Physician, Social Worker or Health Care Professional:

The above named person is applying for the paratransit services in the city where he or she resides. In order to determine whether this applicant is eligible for paratransit services, applicant must provide verification that he/she is unable to utilize public transit services independently due to a disability/disabling health condition. All information provided below is confidential and is used for the sole purpose of establishing eligibility for paratransit services. Please help us determine the eligibility status of this individual by checking and/or completing all of the items below that apply to applicant. Please return this form to the applicant to submit with his/her paratransit application. Thank you.

**1. Please describe the applicant's disability or disabling health condition that prevents use of public transit (i.e. buses and/or BART):**

\_\_\_\_\_  
\_\_\_\_\_

**2. Applicant's condition is:**  Permanent  Temporary until \_\_\_\_\_

**3. Due to the conditions noted above, applicant is unable to use public transit services because he/she:**

- A. \_\_\_\_\_ Cannot walk or travel in a wheelchair or scooter to or from a bus or train stop without the help of another person
- B. \_\_\_\_\_ Cannot board or get off a bus or train without the help of someone else
- C. \_\_\_\_\_ Cannot wait outside by him/herself for a bus or train to arrive
- D. \_\_\_\_\_ Cannot stand and maintain balance on a moving public transit vehicle
- E. \_\_\_\_\_ Cannot see, read and/or comprehend information signs, schedules, maps, etc.
- F. \_\_\_\_\_ Cannot hear and/or comprehend verbal information given by public transit personnel
- G. \_\_\_\_\_ Other reason(s): \_\_\_\_\_

**4. Are paratransit services needed for applicant to obtain life-sustaining treatment?**  Yes  No  
(i.e. dialysis, chemotherapy, radiation therapy, etc.)

**PRACTITIONER'S STATEMENT:** *I hereby state that the information provided above is correct.*

Practitioner's Name: \_\_\_\_\_ (Print/Type) \_\_\_\_\_ (Signature)

Date: \_\_\_\_\_ Discipline:  Physician  Nurse  Social Worker  
 Other Practitioner (describe): \_\_\_\_\_

Agency/Organization Affiliation: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ Email: \_\_\_\_\_