Call-A-Ride Application

GENERAL INFORMATION (Please print) the information on this form will be used solely for the purpose of determining eligibility for Call-A-Ride paratransit service. The information that you provide will be kept strictly confidential.

First Name _____Middle Initial_____

Last Name _____

Street Address _____Apt. Number_____

Mailing Address (if different) _____

City _____ State_____ Zip Code_____

Date of Birth (month / day / year) _____Sex (M/F) _____

Daytime phone _____ Work phone _____

Name and phone number of a friend or relative we can contact in case of an emergency or unable to reach you at your regular number:

Name _____

Relationship _____ Phone Number _____

Race and Ethnic Data

THE FOLLOWING IS FOR STATISTICAL PURPOSES ONLY AND IS VOLUNTARY

____ Applicant declined to answer the above questions

PLEASE MARK ONE ON EACH SECTION

- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ White
- ☐ Asian and White
- ☐ American Indian or Alaska Native and Black or African American
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ American Indian or Alaska Native and White
- ☐ Black or African American and White
- ☐ Other multiple race Combinations greater than one percent

- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino

Signature: _____ Date_____

1. Do you have a disability, which prevents you from using the Basin Transit Association fixed route bus services? _____ Yes _____ No

If yes, please describe any and all physical, mental, visual or functional disabilities, **which prevent** you from using the Basin Transit Association (BTA) fixed route bus services.

_____
_____
_____
_____

If no, please explain why you feel you are eligible for Call-A-Ride.

_____
_____
_____
_____

2. Is your disability a permanent condition? _____Yes _____ No

If no, how long do you expect to have this disability? _____ (Date)

3. Do you use any of the following mobility aids? *(Please check all that apply)*

□ **Motorized wheelchair**	□ **Manual wheelchair**	□ **Powered scooter**
□ **Personal care attendant**	□ **Walker**	□ **Cane**
□ **Crutches**	□ **Service animal**	□ **Prosthesis**

Other: _____

NOTE:

BTA will not transport a mobility aid that exceeds the "common wheelchair" parameters as set forth in the ADA regulation manual (49 C.F.R. Section 37.3), including mobility aid that:

(1) Is longer than 48 inches, measured 2 inches above the ground

(2) Is wider than 30 inches

(3) Weighs more than 600 pounds when occupied

4. Do you travel with someone that assists you?

_____Yes _____ No _____ Sometimes

5. Using mobility aid or on your own, how far are you able to travel without the assistance of another person? (Check all that apply)

__ ½ block __ 1 block __ 2 blocks

__ 4 blocks __ more than 4 blocks

__ climb three 12-inch steps __ wait outside without support for ten minutes

6. How far is the closest bus stop to where you live?

___ within a block ___1/4 mile ___1/2 mile ___3/4 mile ___ unsure

7. Do you currently ride a BTA fixed route bus independently?

_____Yes _____ No _____Sometimes

8. If you do not presently use BTA fixed route services, what are the conditions of your disability, which prevent you from riding the bus?

_____
_____
_____

9. Does weather impact your ability to travel? ____Yes ____ No

If yes, please explain how weather condition(s) impact your ability to ride the fixed route bus.

_____
_____
_____
_____
_____

10. List your most frequent destinations and how you get there currently.

_____
_____
_____

11. Can you cross the street? _____Yes _____ No _____ Sometimes

What best describes your ability to use the BTA fixed route buses?

□ **I can get to and from bus stops if the distance is not too great.**

□ **The severity of my disability or health condition can change from day to day. I can ride the fixed route buses when I am feeling well, but not at other times.**

□ **I have a disability or health condition which prevents me from riding the fixed route buses if the weather is too hot or too cold.**

□ **My disability or health condition makes it difficult or impossible to travel when there is snow and ice.**

□ **I cannot climb stairs to get on and off the fixed route buses.**

□ **I can get to and from bus stops only if there are curb-cuts and level sidewalks.**

□ **I have difficulty understanding or remembering all the things I would have to do to use the fixed route buses.**

□ **I can use the fixed route buses if it's someplace I go all the time.**

□ **I can never use the fixed route buses by myself.**

□ **I would like training information on how to use the BTA fixed route buses.**

□ **I am not able to use the fixed route buses for other reasons. Please explain:**

_____
_____
_____
_____
_____

In order for BTA to evaluate your request for eligibility, it may be helpful for us to contact a professional who is familiar with your health condition or disability and your functional abilities and limitations. Please list two professionals that we can contact if we need addition information. Examples of qualified professionals include:

Family Physician	Psychiatrist	Rehabilitation Specialist
Physical Therapist	Occupational Therapist	Registered Nurse
Case Manager	Independent Living Specialist	Ophthalmologist

Please circle all that apply.

1. Name of Professional: _____

Street Address: _____

City/Town: _____State: _____Zip code: _____

Telephone Number: _____Fax Number: _____

2. Name of Professional: _____

Street Address: _____

City/Town: _____State: _____ Zip code: _____

Telephone Number: _____Fax Number: _____

 I hereby affirm that the statements made herein are true and correct and I understand that falsification of information may result in denial of service.

 I authorize the listed health care professional to release information about my disability and its affect on my ability to travel, which may be needed in connection with my request for Call-A-Ride eligibility certification. It is my understanding that the information released will be used solely to determine my ADA paratransit eligibility. I understand that I may revoke this authorization at any time. Unless earlier revoked, this form will permit the professional listed to release the information described until 60 days after the date appearing below.

 I authorize Basin Transit Association to have access to my disability information in order to assist me in my travel needs.

Applicant's Signature: _____Date: _____

Applicant's Name: _____
(PLEASE PRINT)

If someone other than the applicant completed this form on behalf of the applicant, that person must complete the following:

Name: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Signature: _____ Date: _____

Relationship to Applicant: _____

Send completed application to:

Uintah Basin Association of Governments
Basin Transit Association

330 East 100 South
Roosevelt, UT 84066
(435) 722-4518 Phone
(435) 722-4890 Fax

UINTAH BASIN TRANSIT ASSOCIATION

RELEASE OF MEDICAL INFORMATION AND DISABILITY VERIFICATION

Patient Section (Applicant): Please Print

I _____, authorize my medical provider, _____, to release to Uintah Basin Transit Association Program any information regarding my current physical condition as it relates to disability status.

_____ _____

Signature of Patient or Designee Date

PHYSICIAN SECTION: Please fill out and FAX to the Uintah Basin Transit Association Program at the number below.

I certify that the above named patient is currently under my care, and I consider him/her disabled due to the condition(s) checked below:

- ☐ - He or she cannot walk two hundred feet without stopping to rest
- ☐ - Cannot walk without the use of, or assistance from, a brace, cane, crutch, another person, prosthetic device, wheelchair, or other assistive devices
- ☐ - Is restricted by lung disease to such a degree that the person's forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter, or the arterial oxygen tension is less than sixty mm/hg on room air at rest
- ☐ - Uses portable oxygen
- ☐ - Has a cardiac condition to the degree that the person's functional limitation is classified (according to American Heart Association standards) in severity as Class III or Class IV
- ☐ - Is severely limited in their ability to walk due to an arthritic, neurological, or orthopedic condition
- ☐ - Has the following medically determined physical or mental disability expected to last longer than six months.
  Describe:_____

Is the disability status considered PERMANENT? ..... Yes ☐ No ☐

_____ _____

Name of Physician Signature of Physician

_____ _____

Office Telephone Number Date

CONFIDENTIALITY STATEMENT: Confidentiality agreements are in place and laws regarding the confidentiality and transport of medical information are enforced.

This form must be faxed to the Basin Transit Association Program by the doctor's office to be valid. Please return within 5 business days.

Basin Transit Association Program: Fax 435-722-4890 Attention: _____