

To All Interested Persons:

In 1975, County Express began serving the City of Hollister with its Dial-A-Ride service. To serve a larger part of the community, County Express expanded its services to include Fixed Route, Intercounty, and Paratransit services. As a result, County Express has been providing over 150,000 rides to San Benito County residents and visitors every year.

Dial-A-Ride is not available to residents living within less than three-quarters ($\frac{3}{4}$) mile of Fixed Route Services. Persons with a disability that prevents him/her from independently using the Fixed Route Services in Hollister, may use County Express' Paratransit Service if he/she is qualified. The Paratransit service provides door-to-door service to and from the one-half mile area from a Fixed Route.

County Express follows the Americans with Disabilities Act (ADA) of 1990 eligibility standards for Paratransit services. People with disabilities in the following categories are eligible to receive Paratransit services.

Category 1 – Applicants who cannot independently use County Express Fixed Route service.

Category 2 – Applicants who can use or learn to use an accessible transit system, but the system is not fully accessible.

Category 3 – Applicants who have a specific impairment that prevents them from getting to or from a bus stop.

If you believe that you qualify for County Express's Paratransit service, please complete the attached application and mail it to:

San Benito County Local Transportation Authority
330 Tres Pinos Road, Suite C7
Hollister, CA 95023

All information provided during the certification process *will be kept strictly confidential*. The questions on this application are designed to provide assistance in determining your functional abilities. *A separate medical verification is not required as part of this application process*. However, you are asked to provide the names of two individuals who can confirm the information you provided in your application.

All information regarding the certification process and Paratransit services will be made available in accessible formats upon request.

Should you have any questions, please contact the Local Transportation Authority at (831) 637-7665.

Sincerely,

Betty LiOwen, Transportation Planner

SAN BENITO COUNTY LOCAL TRANSPORTATION AUTHORITY

INSTRUCTIONS AND APPLICATION FOR PARATRANSIT ELIGIBILITY

County Express' Paratransit services are for individuals that cannot independently use the Fixed Route service, the closest bus stop is not yet accessible, or there is a physical barrier to get to or from the bus stop. If you believe that you have a disability that prevents you from independently using the Fixed Route service in Hollister, please complete the following application.

When completing the application please be sure that:

- ✓ You have answered all questions clearly in ink or typed
- ✓ You have included the name, phone number & fax number of the licensed professional who is familiar with your disability or health related condition
- ✓ You have signed Part 4.

If you would like to have your doctor fill out the doctor's verification form at an upcoming doctor's visit, please check the box that says "Please send me a doctor's verification form," and the form will be sent to you. If you do not check the box, the Local Transportation Authority will send one to your doctor on your behalf.

If you are completing the application electronically, you will have to print out the entire application after you have completed it. Please remember to sign Part 4 as we do not currently accept electronic signatures. If you do not sign Part 4, your eligibility determination may be delayed.

It is important to **complete all parts** of this form. ***Applications that are not complete, legibly written, and signed will be returned, which will delay the eligibility determination.*** If you have any questions about the application, please call the Local Transportation Authority at (831) 637-7665.

Once the application has been received, the Local Transportation Authority will determine eligibility on a case by case basis. Eligibility is based on one or more of the criteria mandated by Federal law, the Americans with Disabilities Act (ADA).

Within 21 days of receipt of your application, a letter of determination will be sent to you. If you are eligible, a letter of approval and your Paratransit card will be sent to you. If are not eligible, the letter will explain reasons for the determination of ineligibility; and you have the right to appeal the ineligible decision within 60 days in writing.

After completing the application, please submit it by mail or in person to the following address:

San Benito County Local Transportation Authority
330 Tres Pinos Road, Suite C7
Hollister, CA 95023

Thank you for choosing County Express. We look forward to serving you.

The information obtained in this certification *will be kept strictly confidential*. The questions on this application are designed to provide assistance in determining your functional abilities. It is possible that after review of your application, you may be asked to verify the information contained herein or you may be asked to provide additional information. This may require a telephone or personal interview.

It is important to **complete all parts** of this form. ***Applications that are not complete, legibly written, and signed will be returned, which may delay your eligibility determination.***

PART 1: GENERAL INFORMATION

Mr. Mrs. Ms.

Full Name (First, Middle, Last): _____

Date of Birth: _____ Primary Language: English Spanish Other: _____

Daytime Phone: _____ Evening Phone: _____

Home Address: _____ City: _____ Zip: _____

Are you a new applicant or renewing your eligibility?

If renewing, what is your Paratransit I.D. Number? (Your I.D. number can be found on your eligibility card). _____

If mailing address is not the same as above, please provide below:

Mailing Address: _____ City: _____ Zip: _____

If assistance was provided in filling out this form, please indicate by whom:

Full Name (First and Last): _____ Phone: _____

Relationship: _____ Contact for more information directly? Yes No

Please provide the name and phone numbers of a person we can call in case of an emergency.

Full Name: _____ Relationship: _____

Daytime Phone: _____ Alternate Phone: _____

Please send me a doctor's verification form.

DO NOT WRITE BELOW THIS LINE

Record Number: _____

Status: ___ Approved ___ Denied ___ In Progress

I.D. Number: _____

Determination Date: _____

Date Received: _____

Expiration Date: _____

Application Received: ___ Complete ___ Incomplete

Processed By: _____

Application Sent Back: ___ No ___ Yes Date: _____

Approved By: _____

Eligibility Default Date: _____

Database Entry Date: _____

Date of 1st Attempt Contact: _____

Progress Notes: _____

Date of 2nd Attempt Contact: _____

Date of 3rd Attempt Contact: _____

Date of Doctor Approval: _____

PART 2: CURRENT USAGE AND ACCESS OF FIXED ROUTE

Please answer the following questions in detail—your specific answers to the questions will help us in determining your eligibility.

1. Have you ever used County Express' Fixed Route bus service or similar service in other areas?
 - Yes, usually _____ times a week.
 - Yes, but I stopped because _____.
 - I have never used fixed route buses.

2. If you currently do not use the Fixed Route buses, is there something that might help you ride them? (Check all that applies)
 - Yes, if bus stops were closer to where I live and where I need to go.
 - Yes, if I could learn to use the County Express system.
 - Yes, if route and schedule information was easily accessible.
 - Yes, if *(describe)* _____.
 - No, nothing would help me ride the Fixed Route buses.

3. How far from your home is the nearest bus stop?
 - Less than 1 block. 1-2 blocks. 3-4 blocks. 5 or more blocks. I don't know.

PART 3: DISABILITY AND/OR HEALTH-RELATED CONDITIONS

1. What is your disability or health-related condition that prevents you from using Fixed Route service? How does your disability or health-related condition prevent you from using the Fixed Route service?

 - a. The conditions you described are: Permanent Temporary
 - b. If temporary, what is the date of expected recovery? _____
 - c. If pregnant, what is your due date? _____

2. Does your health condition or transportation disability change from day to day in a way that affects your ability to use public buses?
 - Yes, good on some days, bad on others. No, doesn't change. I Don't Know
 - a. If "Yes" or "I Don't Know" is selected please briefly explain below.

3. For the following (a-g), indicate whether you independently are able to perform the following functions.
 - a. Are you able to understand directions needed to complete a trip or public transit? (This does not refer to being unaccustomed to the English language.)
 - Yes No Sometimes I'm Not Sure

6. Are you a customer of another Paratransit System? Yes No

a. If you are, please provide the following information and a photocopy of your current card.

Name of Paratransit System: _____ Expiration Date: _____

PART 4: APPLICATION CERTIFICATION AND PROFESSIONAL AUTHORIZATION

I certify that the information in this application is true and correct. I understand that falsification of the information may result in denial of service. I understand all information will be kept confidential, and only the information required to provide the services I request will be disclosed to those who perform the services. I understand that it may be necessary to contact a professional familiar with my functional abilities to use public transit in order to assist in the determination of eligibility.

I hereby authorize the professional(s) listed below to provide any information required to complete this certification. The information released will be used solely to determine my eligibility and I realize that I have the right to receive a copy of this authorization. I understand that I may revoke this authorization at any time.

Applicant/Guardian’s Signature _____ Date _____

If you are signing with a mark or “X,” two witnesses will be required. Each witness must be an adult and must complete the required information below. By signing as a witness, you are certifying that you have witnessed the applicant signing the application.

Witness A	Witness B
Full Name: _____	Full Name: _____
Address: _____	Address: _____
Phone Number: _____	Phone Number: _____
Signature: _____	Signature: _____
Date: _____	Date: _____

 Name of Primary Physician or Caseworker: _____

Office Number: _____ Fax Number: _____

Address: _____ City: _____ Zip: _____

 Name of Secondary Physician or Caseworker: _____

Office Number: _____ Fax Number: _____

Address: _____ City: _____ Zip: _____