# Application for Recertification

**All information will remain confidential.**
**Please fill out in ink.**

In order to maintain your ADA Paratransit services all questions on this application must be answered in full. **Failing to return a completed application will result in the delay of your transportation services**. Either you or someone familiar with your condition may complete this form.

If further documentation is needed to make an evaluation, you will be contacted by the Eligibility Intake Coordinator.

Once the application is complete, please return it to:

Easy Lift Transportation
53 Cass Place, Suite D
Santa Barbara, CA 93117

If you have any questions about this application, please call our Eligibility Intake Coordinator at (805)845-8963.

## *Section 1*

# ADA PARATRANSIT ELIGIBILITY APPLICATION

*To be completed by the applicant or assistant*
***Please type or print the following information***

Name: _____ Date of birth: _____ ☐ M ☐ F

Address: _____ Unit #: _____

City: _____ State: _____ Zip: _____ Complex: _____

If this is a "Gated Community", please provide gate code: _____

Day Phone #: _____ Evening #: _____ Cell # _____

Email: _____

Mailing address if different: _____

*Please provide the name of a **Local** friend or relative to call in case of emergency*

Name: _____ Relationship: _____

Day Phone #: _____ Evening #: _____ Cell #: _____

Email: _____

*ALL INFORMATION IS CONFIDENTIAL AND WILL NOT BE DISCLOSED TO OTHERS.*

Please check below how you would like written material sent to you in the future.

□ Regular Print □ Large Print □ Audio Tape □ Braille □Spanish (español)
□ Email: _____

1. What is the health condition or disability which prevents you from using the regular bus service? _____
2. Is your condition? □ Temporary □ Permanent

   *If temporary, how long would you need our services?* _____
3. Do you ever need to bring someone with you to help you when you travel? Ie. A personal care assistant, an aide □ Yes, always □ Yes, sometimes □ No
4. Are you able to travel alone and be left unattended? □ Yes □ No
5. Which one of the following mobility aids, if any, do you use?

□ Crutches □ Power Wheelchair □ Service/Guide Animal
□ Cane □ Power Scooter □ Portable Oxygen
□ Walker □ Manual Wheelchair □ Other _____ □ None

6. Please state name and phone number of the person who will be making reservations for the passenger _____

7. Are you and your wheelchair a combined weight of ***over*** 600lbs?* □ Yes □ No

***Please Note**: A wheelchair or other mobility device must be able to fit onto our bus/paratransit lift. This means it must be no more than 30" wide and 48" long when measured 2" from the floor, and weigh less than 600 pounds, when occupied.*

## *Section 2*

## INFORMATION ABOUT YOUR FUNCTIONAL ABILITIES

WITHOUT the help of someone else can you….

| | Always | Sometimes | Never | Not Sure |
|---|---|---|---|---|
| **1.** Ask for and understand written or spoken instructions? | | | | |
| **2.** Cross the street? | | | | |
| **3.** Stand for 15 minutes if there is no place to sit? | | | | |
| **4.** Step on and off a sidewalk from a curb? | | | | |
| **5.** Find your own way to the bus stop if someone shows you the way once or twice? | | | | |
| **6.** Walk up and down three steps if there is a handrail? | | | | |
| **7.** Walk up and down a flight of stairs if there is a handrail? | | | | |
| **8.** Stand on a moving bus holding onto a handrail? | | | | |
| **9.** Transfer from one fixed route bus to another? | | | | |
| **10.** Are there any walls barriers or obstacles that block your path to the nearest bus stop? | | | | |

**11.** Under the best of conditions, what is the FURTHEST you can walk outdoors (or travel using your mobility aid) without the help of another person?

☐ Less than 1 block ☐ 1 block ☐ 2 blocks (1/4 mile) ☐ 4 blocks (1/2 mile)

☐ 6 blocks (3/4 mile) ☐ More than 6 blocks ☐ I cannot travel outdoors alone at all

**12.** Is there anything else you want to tell us about your disability or health condition that might help us better understand your travel abilities and limitations?

_____
_____
_____
_____

## *Section 3*

## CERTIFICATION OF APPLICANT

- I hereby certify that, to the best of my knowledge, information given in this application is correct.
- I understand that this application will not be processed if it is not complete.
- I understand that the results of the review will be based on my ability to use regular bus transport and may require additional information from me, such as a phone or personal interview or additional consultation with my physician or other professional.
- I agree to notify Easy Lift Transportation, Inc. if I no longer need to use the ADA Paratransit Service.
- I further understand that my ADA Paratransit Eligibility Approval may be reassessed or revoked at any time, if eligibility was granted based on information which is found to be inaccurate, false, or which has changed significantly enough to warrant a change in category.

**Signature of Applicant**: _____ **Date**: _____

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

Name of person completing or assisting with the application (*please print*)

_____

Relationship to Applicant: _____

**Signature of Assistant**: _____ **Date**: _____

Daytime Phone: (_____) _____-_____ Evening Phone: (_____) _____-_____