Chapel Hill Transit EZ Rider ADA Eligibility Application

6900 Mill House Road, Chapel Hill, NC 27516

Phone: (919) 969-4919 * Website: chtransit.org

Email: EZRiderCertifications@townofchapelhill.org

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Chapel Hill Transit – Providing Safe, Reliable and Courteous service to Chapel Hill, Carrboro and the University of North Carolina at Chapel Hill communities.

CHAPEL HILL TRANSIT EZ RIDER ADA ELIGIBILITY APPLICATION

Chapel Hill Transit (CHT) is committed to providing quality transit services to all of our new and existing customers. CHT's Paratransit (EZ Rider) Service provides origin-to-destination transportation to Paratransit certified (eligible) individuals who are unable to use the accessible fixed route system due to their disability in conjunction with the Americans with Disabilities Act (ADA) of 1990. This origin-to-destination service connects individuals who meet the eligibility requirements to wherever they wish to travel within our coverage area. If you have a disability that prevents you from using a lift equipped CHT buses, some, or all of the time, you may be eligible for EZ Rider services.

In order to use ADA paratransit service, you must be certified as eligible. Eligibility is determined on a case-by-case basis. According to ADA regulations, eligibility is strictly limited to those who have specific limitations that prevent them from using accessible public transportation.

EZ Rider is an advanced reservation transportation service which operates service throughout the Towns of Chapel Hill, Carrboro and the University of North Carolina – Chapel Hill communities. Service boundaries are any location within ¾ mile of a CHT fixed bus route. Individuals who reside outside of our service boundary may still be eligible for EZ Rider service as long as they travel within our coverage area. To verify if your address falls within CHT's service boundary, contact the EZ Rider Certification Reviewer at (919) 969.4920.

HOW DO I APPLY FOR EZ RIDER TRANSPORTATION?

Applying for ADA service with CHT requires at least a two-part process. In order to complete the certification (eligibility) process, Parts A & B (explained below) are required. Part C – Medical Release of Information & Part D – Eligibility Release of Information are optional. It is very important Parts A & B are completed fully prior to submission.

1. Personal Information (Part A): Be sure to PRINT clearly and legibly (where indicated). Incomplete applications or applications that are not legible will delay the eligibility process. Email and scanned copies are now accepted.

2. Health Care Verification (Part B): The Healthcare Professional Verification Form (Part B) must be completed by a licensed clinician that knows your condition(s) best. The

Registered Health Care Professional can be any currently licensed Physician, Nurse, Licensed Clinical Social Worker (LCSW), Occupational Therapist, etc. of your choosing.

3. Medical Release of Information (Part C) - Optional: If you would like us to share this information with another transit organization or speak directly with your medical provider, fill out this form. Otherwise, you do not have to complete this form. Form C & D

4. Eligibility Release of Information (Part D) - Optional: There are often times eligible individuals will request to have their Determination of Eligibility documentation forwarded to another transportation agency. Individuals are required to provide CHT written permission to have their eligibility information forwarded to other agencies. By completing this form in advance, the eligible customer will have the authorization on file for the entire time the applicant is certified during each eligibility period. This form is only valid during the eligibility period.

All requested documents must be completed prior to submission to CHT's EZ Rider Certifications Office. All completed applications submitted to EZ Rider Certifications will be processed within twenty-one (21) calendar days. If we are unable to read your document, we may call to clarify information prior to deciding.

Submitting an incomplete application may require CHT to return the incomplete documents which may, in turn, delay the eligibility process.

Once a completed application for EZ Rider service has been received, CHT will notify the applicant by mail the Determination of Eligibility within twenty-one (21) calendar days. If the Determination of Eligibility exceeds twenty-one (21) calendar days, then the applicant may contact EZ Rider Certifications (919.969.4920) to request use of the transportation service until a determination has been made.

Upon submission, the completed application may be subjected to approval for either of the following:

1. Unconditional Eligibility (Full) – The customer may use paratransit services under any circumstances.

2. Conditional Eligibility (Limited) – The customer may use paratransit services only under certain circumstances.

Upon submission, the completed application may also be denied. If you are determined ineligible or conditionally eligible for EZ Rider services, then you may request an appeal

by filing a written Notice of Appeal letter to CHT The appeal will provide an opportunity for the applicant and/or representative to be heard, to present information and arguments before the Appeals Committee. Applicants submitting written appeals to CHT's Transit Administrator shall be provided with written notification of the decision and reasons for the decision within thirty (30) days of the hearing.

Applicants and persons assisting the applicant are encouraged to review the EZ Rider Rider's Guide before completing the attached forms.

Thank you for choosing Chapel Hill Transit's EZ Rider service to serve your transportation needs. Should you have any questions or concerns, please feel free to contact EZ Rider Certifications via telephone at (919) 969.4920.

Completed applications may be returned in-person, mailed, or emailed to:

Chapel Hill Transit
EZ Rider (ADA) Certification Reviewer
6900 Millhouse Road
Chapel Hill, NC 27516

EZRiderCertifications@townofchapelhill.org

Phone: (919) 969.4920 ~ Fax: (919) 968.2808

PART A – PERSONAL INFORMATION: This section is to be completed by the applicant or representative. Please be sure to PRINT legibly. Please check ALL that apply.

Name (first, middle, last):

_____

Preferred Name:

_____

Birth Date: _____/_____/_____Gender: ☐ Woman ☐ Man
☐ Transgender ☐ Non-binary/non-conforming ☐ Prefer not to respond

Primary Language (please check): ☐ English ☐ Spanish ☐ Other (specify): _____

Home Address: _____

Apt. #: _____

City: _____State: _____

Zip: _____

Community Name (Subdivision, Apartment Complex, etc.):

_____

Mailing Address (if different from address listed above):

_____Apt. #: _____

City: _____State: _____

Zip: _____

Home Phone: ( ) _____Work Phone: ( ) _____

Cell Phone: ( ) _____

Email Address: _____

How would you like to receive ride notifications? (Check ALL that apply)

☐ Phone ☐ Mobile Text ☐ Email

In case of emergency, whom should we contact?

Name: _____Relationship: _____

Daytime Phone: ( ) _____Evening Phone: ( ) _____

PART A - PERSONAL INFORMATION (continued)

1. Do you currently use any regular fixed route bus services? ☐ Yes ☐ No

a. If yes, which routes? _____

b. Where is the closest bus stop located near your home? _____

c. How long could you wait at a bus stop for the next bus to arrive?

☐ Less than 5 minutes ☐ 5 minutes ☐ More than 5 minutes

d. Can you get to this bus stop by yourself? ☐ Yes ☐ No

2. If no, what limits you from getting to this bus stop?

_____

3. If you had to wait outside at a bus stop, you would have to have:

☐ Bench ☐ Shelter ☐ Nothing

4. If you had to cross a street, you would need to have: ☐ Curb Cut(s)

☐ Tactile Curb Warning(s) ☐ Accessible Median ☐ Audible Signal(s)

☐ Other: _____(Please be specific.)

5. I can cross a street with up to _____ lane(s) of traffic or ☐ I cannot cross any street.

6. If you had to travel across ground, you would need to have: ☐ Sidewalk(s)

☐ Pavement ☐ Nothing

7. If you had to travel up or down steps (stairs), you would have to have: ☐ Handrail(s)
☐ Nothing; I can travel up or down steps (stairs) without any problems
☐ Nothing; I cannot travel up or down steps (stairs) because:

_____

_____

8. Do you currently require a Personal Care Attendant (PCA) when you travel?

☐ Yes ☐ No

PART A - PERSONAL INFORMATION (continued) –

9. What mobility aid(s), if any, do you use when you travel (Check ALL that apply)?

☐ None ☐ Segway ☐ White Cane ☐ Picture/Alphabet Board ☐ Transfer Board
☐ Walker ☐ Crutches ☐ Scooter ☐ Wheelchair (Manual) ☐ Wheelchair (Electric)
☐ Cane ☐ Oxygen ☐ Boarding Chair ☐ Rollator

☐ Other: _____ (Please be specific.)

If you use a manual and/or electric wheelchair:

i. Please indicate the year, make and model of the device below:

_____

ii. Is the device more than 30 inches wide and/or 48 inches long? ☐ Yes ☐ No

10. Are there any special specific needs that CHT should be made aware of regarding the service we provide and how it affects your disability? ☐ Yes ☐ No

If yes, please provide specific information:

_____

_____

_____

_____

Of the following statements, which best defines the nature of the disability or limitation which prevents you from using fixed route bus service. Be sure to describe your specific needs in the space provided. Please check ALL that apply and be as specific as possible.

☐ I have a **mobility impairment**, which prevents me from getting to and/or getting on a fully accessible vehicle without assistance. ☐ temporary or ☐ permanent?

Describe the nature of this condition and any environmental obstacles (i.e. inclines, curbs, distances, etc.) which affect your ability to access public transportation:

_____

_____

_____

☐ I have an **endurance condition** which prevents me from moving the distance needed to get to the bus stop. ☐ temporary (or) ☐ permanent?

Describe the cause and nature of this condition: _____

_____

_____

☐ I have a **visual impairment** that prevents me from finding my way to and from a fixed route bus stop without assistance. ☐ temporary (or) ☐ permanent?

Describe the nature of your condition and your functional level of vision:

_____

_____

_____

☐ I have a **cognitive impairment** which prevents me from remembering and understanding information needed to get myself safely to and from the bus stop.

☐ temporary (or) ☐ permanent?

Describe the origin and characteristics of your condition:

_____

_____

_____

☐ I have a **severe medical condition**, which limits my ability to function. Describe and note whether your condition is temporary or permanent, and if it is episodic in nature (i.e. do you have "good" days or times when you can access transportation, and "bad" days when you cannot?)

_____

_____

_____

_____

☐ My **functional limitations** does not fit into any of the above categories, and is:
☐ temporary or ☐ permanent? I am unable to use regular bus service because:

_____

_____

_____

This section is to be completed by the applicant or representative. Please be sure to PRINT legibly.

I certify that the information contained in this application is true and correct. I understand that knowingly falsifying the information will 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.

Applicant's Signature: _____ Date: _____

Did someone help you complete this form? ☐ Yes ☐ No

If so, please provide the following information about the person who assisted you in completing the form:

Name: _____ Date: _____

Relationship: _____ Phone No.: _____

Note: It is your responsibility to notify us if your disability improves/worsens enough to change your eligibility status. If your condition improves/worsens after you have been determined eligible or we discover you submitted false information, your eligibility could be modified and/or you may be asked to re-apply.

PART B – HEALTH CARE VERIFICATION: This section is to be completed by your Registered Health Care Professional.

Applicant Name (first, middle, last): _____

Birth Date: _____/_____/_____

You are being asked by the applicant above to provide information regarding their ability to use the regular fixed route bus services provided by Chapel Hill Transit. For those persons who cannot use the regular fixed route bus services, the applicant may be eligible to use the paratransit (EZ Rider) services. The information you provide will allow us to evaluate the applicant's request for EZ Rider and determine their specific needs. Thank you for your cooperation in this matter.

Note: All regular fixed route buses are currently accessible to persons with disabilities who need lift-equipped vehicles, vehicles with kneeling features, and announcements of bus stops. In order to be eligible for paratransit services, the individual must be unable to access these services due to conditions which prevent them from getting to/from a regular fixed route bus stop, transferring between vehicles, and/or conditions which prevent them from being able to get on, ride, or get off a lift-equipped vehicle. Individuals for whom performing these tasks are inconvenient and/or uncomfortable are not eligible for services.

Eligibility for paratransit services is determined on a trip-by-trip basis. It is extremely important that you provide specific information about the individual's functional limitations so such determinations can be made. For example, an individual who can easily and safely get to the bus stop nearest their home may not be able to get to a bus stop at their desired destination and thus may be eligible to use the paratransit services based on the destination.

Please complete the following tasks as outlined below:

1. Read PART A of the application in its entirety. Part A (Personal Information) was completed by the applicant and should be provided for your review and consideration.

2. Complete PART B of the application considering the description of transit services that is provided above.

PART B HEALTH CARE VERIFICATION (continued)

3. Return the completed application to the applicant within seven (7) calendar days of receipt. The applicant is responsible for returning both Part A and Part B of the application to CHT. In the event CHT has any questions or concerns regarding the information you provide in Part B, CHT may contact you via telephone regarding the applicant's abilities.

4. Should you have any questions, please feel free to contact CHT Certifications at (919) 969.4920. Feel free to leave a message, if necessary, as this is a confidential line.

I have read PART A in its entirety: ☐ YES ☐ NO

I Agree with the information provided in PART A: ☐ YES ☐ NO

If no, please explain: _____

Registered Health Care Professional (Name – Please PRINT):

_____

Registered Health Care Professional (Signature):

_____

Agency/Business Name:

_____

Agency/Business Address:

_____

Agency/Business Phone No.:

_____

Professional Affiliation (check the appropriate designation):

☐ Licensed Physician ☐ Licensed Physical Therapist ☐ Licensed Occupational Therapist
☐ Speech Pathologist ☐ Nurse (LPN or RN) ☐ Licensed Psychologist
☐ Licensed Social Worker ☐ Vision Specialist ☐ Certified Orientation/Mobility Specialist
☐ Certified Rehabilitation Counselor ☐ Audiologist
☐ Other: _____

A. Indicate the condition/disability that causes the applicant's disability:

_____

B. Indicate the nature of the applicant's disability (check ALL that apply):

☐ Arthritis

☐ Cognitive Impairment (see below):

If this individual has functional limitations due to a cognitive impairment, please indicate any of the following issues that are pertinent to this individual:

☐ Cannot be left alone to wait for transportation

☐ Displays behavior that is unsafe for self or others using public transportation

☐ Cannot recognize vehicles that applicant should board

☐ Other (Please be specific.): _____

☐ None of the Above

☐ Cardiac Illness

☐ Deaf /Hearing impairment

☐ Kidney Disease (Dialysis): ☐ Yes ☐ No

☐ Mobility impairment (Please be specific.): _____

☐ Severe Muscle Spasms / Seizures

☐ Visual Impairment / Sight Disabilities: ☐ Totally Blind ☐ Legally Blind

☐ Other (Please be specific.): _____

C. For any impairment checked above (except for cognitive impairments), please note any relevant specific precautions from the following:

1. Individual's Travel Distance Limits (with or without a mobility device) to access transportation, in measurable distances – i.e. feet, blocks, miles, etc.?

_____

2. Does the applicant have any limitations regarding travel during a specific time of the day? ☐ Yes ☐ No
Please explain: _____

3. Does the applicant have any limitations regarding travel during certain weather conditions? ☐ Yes; ☐ No
Please explain: _____

4. Does the applicant have any limitations regarding travel during certain environmental conditions (i.e. needs curb cuts, grassy/hilly areas, etc.)?

☐ Yes ☐ No

Please explain: _____

D. What is the severity of this individual's condition?

☐ Mild ☐ Moderate ☐ Severe ☐ Profound

E. What is the expected duration of this individual's condition?

☐ Long-Term: Potential for functional improvements or periods of remission

☐ Permanent: No expectation of functional improvement

☐ Temporary: If Temporary, please provide an approximate expected duration until (mm/dd/yyyy): ____/_____/_____

F. Please provide any additional information you may feel is necessary in assisting CHT in determining eligibility for the applicant:

_____

_____

_____

To the best of my knowledge, the previous information is correct, based on my examination of the applicant and/or my review of official files

Signature: _____ Date: _____

Printed Name and Title: _____

PART C – MEDICAL RELEASE of INFORMATION: This section is to be completed by the applicant. Please be sure to PRINT legibly.

In addition to Parts A & B of the application, the applicant has the option of granting CHT permission to contact the Registered Healthcare Professional in the event CHT needs additional information or clarification regarding the documents submitted on the applicant's behalf. This Registered Healthcare Professional must be the licensed professional who has signed off on the application in Part B. This form is only valid for ninety (90) days from the date of the signed Medical Release of Information form.

Applicant's Name:

_____

Applicant's Address:

_____

I request and authorize (Registered Healthcare Professional's name):

_____

at (business address)

_____

to release my healthcare information to:

Chapel Hill Transit
EZ Rider (ADA) Certifications
6900 Millhouse Road
Chapel Hill, NC 27516
Phone: (919) 969.4920 ~ Fax: (919) 968.2808

I understand that it may be necessary for CHT to contact a professional familiar with my functional abilities to use public transit in order to assist in the determination of eligibility. By signing this form, I hereby authorize the Registered Health Care Professional indicated on this document (who can verify my disability or health related condition(s)), to release this information to Chapel Hill Transit. This information will be used only to verify my eligibility for paratransit services. I understand that I have the right to receive a copy of this authorization and that I may revoke it at any time. I further understand that this authorization expires ninety (90) calendar days after the date indicated below.

Applicant Signature: _____ Date: _____

Please Return Completed Form to the above address.

PART D – ELIGIBILITY RELEASE of INFORMATION: This section is to be completed by the applicant. Please be sure to PRINT legibly.

There are often times eligible individuals will request to have their Determination of Eligibility documentation forwarded to another agency. Individuals are required to provide CHT written permission to have their eligibility information forwarded to other agencies. By completing this form in advance, the eligible customer will have the authorization on file for the entire time the applicant is certified during each eligibility period. This form is only valid during the eligibility period.

Applicant's Name: _____

Applicant's Address: _____

_____

I give CHT permission to release my eligibility information to (check ALL that apply):

☐ GoTriangle (formerly Triangle Transit) ☐ GoDurham (formerly Data Access)
☐ GoRaleigh (formerly Capital Area Transit) ☐ Orange County Public Transportation
☐ Other: _____

Individuals are required to provide CHT written permission to have their eligibility information forwarded to other transit agencies. By completing this form in advance, the eligible customer will have the authorization on file for the entire time the applicant is certified during each eligibility period. I further understand that this authorization will remain active for the duration of my eligibility period (up to four (4) years).

Applicant Signature: _____

Date: _____

Please Return Completed Form to:

Chapel Hill Transit

EZ Rider (ADA) Certifications
6900 Millhouse Road
Chapel Hill, NC 27516
EZRiderCertifications@townofchapelhill.org

Phone: (919) 969.4920 ~ Fax: (919) 968.2808 (reminder to send both sides)