



## ADA Paratransit Services Application

There are two types of public transportation available throughout the State of Delaware:

**Fixed Route Service** (regular city buses) provides service at designated bus stops along specific routes on set schedules. All buses now have features to make riding easier for people with disabilities, including wheelchair lifts, kneeling features, low floor buses, and voice announcements.

**ADA Paratransit Service** (door-to-door) shared-ride public transportation service for people whose disability prevents them from using Fixed Route Service (regular city buses). You must call in advance to make a reservation to travel.

If your disability and/or environmental barriers, prevent you from using Fixed Route service (regular city buses), you may be eligible for Paratransit Service (door-to-door) some or all of the time. Your ability to use fixed route buses will be evaluated through the use of this application, an In Person Interview, and in some cases a functional assessment. A determination will be made within 21 days of your in person interview or presumptive eligibility will be granted. When you are contacted for your in person interview, it is to your benefit to schedule as soon as possible. Your application will not be processed without this step.

**IMPORTANT: Medical condition or eligibility for other disability programs do not necessarily qualify you to use Paratransit Service (door to door). Not having access to fixed route bus service is not a qualifier.**

### **What is the American with Disabilities Act (ADA)?**

The Americans with Disabilities Act (ADA) is a civil rights law. The intent of the ADA is to remove barriers that have prevented people with disabilities from fully participating in life. Under the ADA, Fixed Route service (regular city buses) is to be the primary means of public transportation for everyone, including people with disabilities.

### **Travel Training**

DART offers free one-on-one or group training to teach people with disabilities how to ride Fixed Route buses. If interested, you may call one of our travel trainers for more information:

1 – 800 – 652 – 3278, option 4



## ADA Paratransit Services Application

To ensure your application is processed in a timely manner, **all questions** must be answered. **Part A and Part B must be submitted at the same time.** Incomplete applications will be returned to applicant and/or individual/agency completing application. All information is kept confidential.

### PART A: General information regarding applicant

To be completed by applicant or on behalf of applicant.

☐ Current Rider ☐ New Applicant ☐ Male ☐ Female

Name

Street Address

Name of Group Home/Nursing Home/Apt Complex  
Apt/Suite #

City

State

Zip

Mailing Address if Different:

Phone Number(s)

Date of Birth

ID #

☐ Last 4 digits of Social Security ☐ Driver's License

☐ State ID

☐ Other (Please be specific)

Emergency Contacts:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone # \_\_\_\_\_ / Phone # \_\_\_\_\_

Emergency Contacts:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone # \_\_\_\_\_ / Phone # \_\_\_\_\_

If information is required in an alternative format, please contact our office at  
1-800-652-3278, Option 4

Applicant \_\_\_\_\_

**Questions to applicant regarding disability:**

1. Describe your disability and how you believe it prevents or limits your use of the regular city bus. Please be specific.

2. Is the condition/s temporary? ☐ Yes ☐ No  
If temporary, what is the expected duration?

3. How do you travel now?

☐ Walk ☐ Drive a Car ☐ Ride in a car ☐ Agency Provided  
☐ Taxi ☐ Fixed Route ☐ Paratransit ☐ Fixed Route & Paratransit  
☐ Other \_\_\_\_\_

4. Which of these aids do you currently use when traveling?

☐ Portable Oxygen ☐ Straight Cane ☐ 3-4 Pronged Cane  
☐ Walker ☐ White Cane ☐ Human Guide  
☐ Service Animal ☐ Crutches ☐ Leg Brace  
☐ Prosthetic Leg ☐ Manual Wheelchair ☐ Power Wheelchair  
☐ Power Scooter ☐ Rollator ☐ Alphabet/Picture Board  
☐ Other (Be specific) \_\_\_\_\_

If you use a wheelchair or scooter, is it considered extra wide? ☐ Yes ☐ No

5. Do you need assistance from another person when you travel in the community?

☐ Yes ☐ No ☐ Sometimes  
What type of assistance do they provide for you?

6. Can you climb three steps (11 to 15 inches) with a handrail, without assistance from another person? ☐ Yes ☐ No ☐ Sometimes

7. Have you ever used the regular city bus? ☐ Yes ☐ No

When was the last time you used it?  
If yes, why are you no longer able to use it?

8. Does weather impact your ability to use the regular city bus?

☐ Yes ☐ No ☐ Sometimes  
How?

9. Describe the terrain around your home or apartment in relation to getting to the bus stop (sidewalks, hills, grass, gravel, distance, etc).

Applicant \_\_\_\_\_

10. Are you able to get to the closest bus stop from your home?

☐ Yes ☐ No ☐ Sometimes

If No or sometimes, what prevents you?

11. Can you cross at streets with very little traffic, where there are no traffic controls or stop signs without assistance?

☐ Yes ☐ No ☐ Sometimes

If No or sometimes, what prevents you?

12. Can you cross at traffic lights?

☐ Yes ☐ No ☐ Sometimes

If No or sometimes, what prevents you?

13. Can you cross at busy intersections?

☐ Yes ☐ No ☐ Sometimes

If No or sometimes, what prevents you?

14. Are you able to ask for and follow written or oral information?

☐ Yes ☐ No ☐ Sometimes

If No or sometimes, what prevents you?

15. Are you able to recognize your destination or landmark near your destination?

☐ Yes ☐ No ☐ Sometimes

If No or sometimes, what prevents you?

16. Are you able to tell time? ☐ Yes ☐ No

17. Are you able to count money? ☐ Yes ☐ No

Is there any other information you want to provide that will help us in making an appropriate eligibility determination?

Applicant \_\_\_\_\_

## APPLICANT VERIFICATION

**Application must be signed to be considered complete.**

### Applicant Signature

I understand that the purpose of this application form is to determine if there are times when I cannot use DART Fixed Route buses and will require paratransit services. I understand that the information on this application will be kept confidential and shared only with the professionals involved in evaluating my eligibility. I certify that to the best of my knowledge, the information on this application is true and correct. I understand that providing false or misleading information could result in my eligibility status being terminated.

I give permission for DART staff to contact the professional who has filled out this application or given supplemental verification of my condition.

Applicant Signature X \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

### Person completing this form if other than Applicant (check one):

☐ I certify that the information in this application is true and correct based upon the information given to me by the applicant.

☐ I certify that the information provided in this application is true and correct based upon my own knowledge of the applicant's health condition or disability or I have legal authority to complete this application.

Print Name \_\_\_\_\_ Day Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

Agency Name \_\_\_\_\_

**Part A and Part B must be submitted together.**

**If only one section is received, it will be returned to applicant.**

**Mail To: Eligibility Section**

**900 Public Safety Blvd**

**Dover, DE 19901**

**OR Fax To: 302-760-2932** If application is faxed, do not mail a copy.

Applicant \_\_\_\_\_

**Dear Health Care Professional:**

In order to complete this application on behalf of the applicant, you must be either a certified or license professional. [If you feel you are qualified to complete this application as a health care professional, but do not have a certification or license number, please contact DART at 1-800-652-3278, Option 4 and request to speak to the Eligibility Supervisor for approval to complete]

The applicant is asking you to complete and sign Part B of this form certifying that they have a disability that prevents them from using fixed route bus service (regular city buses). This information will be used to help determine whether or not the applicant needs to use paratransit (door-to-door) service or is able to use fixed route service for all or some of their travels.

Under the Americans with Disabilities Act (ADA), if a person has the functional and cognitive ability to use DART Fixed Route buses, that person is not eligible for paratransit services. Disability alone, distance to and from a bus stop, or the availability of fixed route bus service, is not by itself, a qualifier for paratransit services. Eligibility for other programs is also not a qualifier.

All DART Fixed Route buses are lift equipped for use by individuals using wheelchairs or by individuals who are not able to use steps. Additionally, DART has kneeling buses, which lowers the bus to the ground, making the first step from the curb easier to make. DART also offers travel training to assist persons with disabilities to use the fixed route bus service to enhance their independence.

If you have any questions while completing Part B, please contact us at 1-800-652-3278, Option 4.

**Please note: If you do not have Part A, you will need to return Part B to the applicant. We must receive both part A and Part B as one submission.**

**Who can complete Part B: [must be licensed/certified]**

Vocational Rehabilitation Counselor	O & M Instructor
Social Worker	Physician
Respiratory Therapist	Physician Assistant
Psychologist	Nurse Practitioner
Psychiatrist	Physical Therapist
Audiologist	Optometrist / Ophthalmologist
Independent Living Specialist	Registered Nurse

Applicant \_\_\_\_\_

**PART B** – To be completed by a **Licensed/Certified** Health Care Professional who has knowledge about the applicant's functional ability. Part B must be returned with Part A.

**Required Information – Licensed/Certified Health Care Professional**

Name (Please print) \_\_\_\_\_  
Signature \_\_\_\_\_  
Professional Title \_\_\_\_\_  
Area of Professional Specialization \_\_\_\_\_  
Professional License # \_\_\_\_\_  
Clinic or Agency \_\_\_\_\_  
Address \_\_\_\_\_  
Phone Number \_\_\_\_\_

**Questions Regarding the Applicant's Disability – Please complete all sections that apply.**  
**Incomplete applications will be returned to applicant.**

**General Medical or Physical Disability Information**

Applicant has been a patient of mine since: \_\_\_\_\_  
Date of applicant's last evaluation: \_\_\_\_\_

1. Please indicate the nature of your patient's condition or disability. This list is not all inclusive, it lists what we predominantly see on submitted applications.

- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ Dialysis? Yes No
- ☐ Undergoing Cancer Treatment Expected Duration: \_\_\_\_\_
- ☐ Arthritis: Please specify type and area/s: \_\_\_\_\_
- ☐ Amputation: Please specify extremity and/or use of prosthesis: \_\_\_\_\_
- ☐ Neurological Condition/Cognitive (Circle one) Mild Moderate Severe Profound
- ☐ Neuromuscular Condition
- ☐ Pulmonary Disease: If on oxygen, what is usage: \_\_\_\_\_
- ☐ Cardiac Disease
- ☐ Mental Illness
- ☐ Traumatic Brain Injury
- ☐ Legally Blind
- ☐ Severely Visually Impaired
- ☐ Alzheimer's
- ☐ Dementia
- ☐ Autism
- ☐ Hearing Impairment (Specify degree of hearing loss)
- ☐ Seizures
- ☐ Other \_\_\_\_\_

2. Is the condition/s temporary? ☐ Yes ☐ No  
If temporary, what is the expected duration? \_\_\_\_\_

Applicant \_\_\_\_\_

3. Are there environmental conditions that would have a negative impact on the applicant's condition/s? ☐ Yes ☐ No  
What are the conditions?  
What is the impact?

4. Do you feel the applicant could be trained to independently use regular city buses safely and effectively? Yes No If no, Why?

5. How far do you feel the applicant could independently propel a wheelchair or ambulate with or without a mobility aid, and without lengthy rest breaks?  
☐ No independent functional mobility ☐ Less than ½ mile  
☐ \_\_\_\_\_ Blocks (500 feet = 1 block) ☐ Greater than ½ mile

6. How long can the applicant wait at a bus stop with a bench/shelter?

7. How long can the applicant wait at a bus stop **without** a bench/shelter?

**8. Seizure Disorders**

Type(s) of seizures? \_\_\_\_\_

How often do the seizures occur? \_\_\_\_\_

After a seizure, how long does it take before the applicant is able to function safely? \_\_\_\_\_

Are the seizures preceded by an aura? ☐ Yes ☐ No

What triggers the applicant's seizure? \_\_\_\_\_

Is the applicant taking medication for the seizures? ☐ Yes ☐ No

Are the seizures currently controlled? ☐ Yes ☐ No

Is he/she able to function safely and effectively in the community? ☐ Yes ☐ No

When was the applicant's last seizure? \_\_\_\_\_

**Cognitive Disability**

1. What is the formal diagnosis of the applicant's condition?

2. Does the applicant have any specific behavioral problems? ☐ Yes ☐ No  
If Yes, describe:

3. Is the applicant able to travel alone? ☐ Yes ☐ No

4. Does the applicant have the ability to follow directions?

☐ 1 Step Directions ☐ 2 Step Directions ☐ 3 Step Directions ☐ None

5. Would the applicant know what to do if he/she became lost while out in the community?  
☐ Yes ☐ No



Applicant \_\_\_\_\_

### Cognitive Disability (Continued)

6. Would the applicant be able to recognize and avoid dangers he/she might encounter when traveling in the community? ☐ Yes ☐ No  
If No, explain:

7. Does the applicant have the ability to safely cross streets? ☐ Yes ☐ No

8. Please check all that apply to applicant and provide additional information if necessary:

- ☐ Problem Solving
- ☐ Short-term Memory
- ☐ Attention
- ☐ Processing
- ☐ Foresight/Planning
- ☐ Safety Awareness/Judgment

How would these prevent the applicant from being able to safely use regular city buses?

9. Is the applicant currently enrolled in any programs? ☐ Yes ☐ No If yes, please list.

### Behavioral Health

1. What is the formal diagnosis of the applicant's condition?

2. What is the prognosis for this condition for independent function?

3. Has the applicant been prescribed medications for his/her condition? ☐ Yes ☐ No  
If yes, does this medication allow the applicant to function safely in the community? ☐ Yes ☐ No

4. Has the applicant recently had a decline in function due to an adjustment in medication?  
☐ Yes ☐ No Describe:

5. Does the applicant experience auditory or visual hallucinations? ☐ No ☐ Yes – How do the hallucinations impair the applicant's ability to function in the community?

6. Does the applicant have anxiety or panic attacks in closed/crowded spaces? ☐ No ☐ Yes  
Please explain

7. Are there life skills that the applicant lacks that would prevent him/her from safely using regular city buses? ☐ No ☐ Yes If yes, please explain

Applicant \_\_\_\_\_

### Vision Disability

1. What is the formal diagnosis of the applicant's condition?

2. Best Corrected Vision:

3. What is the prognosis? Is this condition stable, degenerative or otherwise changing?

4. Is the individual able to walk outdoors alone? ☐ Yes ☐ No

If yes, where can the applicant walk?

☐ Only on his/her own property and to familiar places

☐ To places nearby (for example, on the same block)

☐ To places further away

5. If applicant is able to travel outdoors alone, is he/she able to cross streets without help?

☐ At quiet streets with very little traffic

☐ At traffic lights

☐ At busy intersections

☐ With auditory cross signals only

☐ Other

**If the applicant is partially sighted:**

6. Is he/she able to see steps or curbs? ☐ Yes ☐ No

7. Is his/her vision affected by different lighting conditions?

☐ Bright sunlight

☐ Dimly lit or shaded places

☐ ☐ Nighttime

☐ Other

8. Is the applicant's ability to travel outside alone affected by other conditions?

☐ Yes ☐ No (Consider impact of environmental noise and ability to distinguish traffic flow patterns.  
Please explain:

Is there any other information you want to provide that will help us in making an appropriate eligibility determination?

**Mail or Fax Complete Application (Part A & B must be submitted together)**

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**END OF APPLICATION: PAGE 10 OF 10 / Revised November 2015**