

**Grand Valley Transit - GVT**  
**ADA Paratransit Eligibility Application – 2019**

Updated September 2017

In accordance with the Americans with Disabilities Act of 1990 (ADA), Grand Valley Transit provides paratransit or “origin to destination” service to anyone with a functional limitation which prevents them from using public transportation and who is traveling within the area served by **GVT** buses. Paratransit service is intended only for those trips that the person cannot make on **GVT** fixed route buses. This application form is intended to determine when and under what circumstances the applicant can use Grand Valley Transit fixed route buses and when paratransit service is required.

Grand Valley Transit will only use the information obtained in this application for the provision of curb-to-curb transportation services. Information may be shared with other transit providers to facilitate travel in other service areas at the applicant’s request. The information will not be provided to any other person or agency.

**Instructions for completing this form**

Before completing this application please read the enclosed Eligibility Criteria Brochure to learn more about paratransit services.

The applicant (or someone assisting the applicant) must complete sections A through E. A licensed professional from the list provided must complete and sign the Professional Verification.

All applicants, whether new or applying for recertification, must complete a new application.

All questions must be answered. Incomplete forms will be returned.

If you have any questions or need assistance completing this form, please contact us at 970-256-7433. Mail completed forms to:

Grand Valley Transit  
525 S. 6<sup>th</sup> Street, First Floor  
Grand Junction, CO 81501

## GENERAL INFORMATION

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ Apt#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Phone: (\_\_\_\_) \_\_\_\_\_ TTY: Yes No

Evening Phone: (\_\_\_\_) \_\_\_\_\_ TTY: Yes No

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M F

Do you need future written information provided to you in an accessible format?  
\_\_\_\_Yes \_\_\_\_No

Emergency Contact Person:

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

Day Phone: (\_\_\_\_) \_\_\_\_\_ Eve. Phone: (\_\_\_\_) \_\_\_\_\_

### A. INFORMATION ABOUT YOUR DISABILITY AND MOBILITY EQUIPMENT

1. What type or types of disabilities prevent you from using Grand Valley Transit? Please check all that apply.

Physical disability

Visual impairment/Blindness

Developmental disability

Brain injury

Mental illness

Other \_\_\_\_\_

2. Please describe your disability (or disabilities) in more detail, including the diagnosis (or diagnoses).

\_\_\_\_\_  
\_\_\_\_\_

3. Please indicate all of the mobility aids or equipment you use when traveling outside your home.
- |  |  |
|--|--|
| <input type="checkbox"/> Communications Device | <input type="checkbox"/> Long white Cane   |
| <input type="checkbox"/> Cane                  | <input type="checkbox"/> Manual Wheelchair |
| <input type="checkbox"/> Powered Wheelchair    | <input type="checkbox"/> Scooter           |
| <input type="checkbox"/> Crutches              | <input type="checkbox"/> Walker            |
| <input type="checkbox"/> Leg braces            | <input type="checkbox"/> Prosthesis        |
| <input type="checkbox"/> Service Animal        | <input type="checkbox"/> None              |
| <input type="checkbox"/> Other: _____          |  |

## **B. INFORMATION ABOUT YOUR VISION**

1. Cause of vision loss/ Diagnosis:  
\_\_\_\_\_
2. Are you totally blind? \_\_\_\_Yes \_\_\_\_No If yes, skip to question #7.
3. My vision is worst during these conditions. Check all that apply:
- Bright sunlight
  - Dimly lit or shaded places
  - Nighttime
  - I see the same in different lighting conditions
4. My eye condition is considered to be:
- Stable
  - Degenerative
  - Other (please explain)  
\_\_\_\_\_
5. I am able to use my vision to consistently identify the following signs and environmental features, as they relate to traveling to the transit stop and using fixed route service. Please check all that apply:
- The color of traffic lights
  - Pedestrian Walk/ Don't Walk signals
  - Crosswalk markings
  - Curbs or curb ramps
  - Level changes along the walking path
  - Bus/transit stop signs that indicate the location of the stop
6. Anything else you wish to tell us about your vision in regards to mobility within the community?

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7. Most often, I use the following mobility aids when I walk outside:

Please check all that apply:

- Sighted (person) guide
- Guide dog
- White cane
- Optical devices (telescope, light, special glasses, etc.)
- None of the above
- Other, please list: \_\_\_\_\_

8. When I'm not sure of which way to go or when to cross a street, I am able to request and understand instructions or utilize assistance.

\_\_\_ Yes \_\_\_ No \_\_\_ Sometimes

9. My hearing is normal: \_\_\_ Yes \_\_\_ No

If No, please describe your functional hearing problems.

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**C. INFORMATION ABOUT YOUR CURRENT USE OF FIXED ROUTE SERVICES OR PARATRANSIT SERVICES**

1. Do you currently use Grand Valley Transit by yourself?

\_\_\_ Yes \_\_\_ No

If YES continue, if NO, go to question #5.

2. If yes, how often? (Circle the choice that best applies to you)

Daily   Several times per week   At least once per month   Rarely

3. When was the last time you independently used Grand Valley Transit?

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4. If you need the assistance of another person to travel while using the bus, what assistance does this person provide?

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5. You indicated that you do not use Grand Valley Transit. Why not?

Please check all that apply:

- The closest stop is too far from my house
- I do not know how to ride Grand Valley Transit
- I cannot travel by myself between the bus stop and my destination
- I'm afraid to use Grand Valley Transit
- I do not want to use Grand Valley Transit
- Other (explain)

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6. Please list destinations for which you use or need Paratransit services and the reasons why you are unable to use fixed route services for those trips.

a. Destination and address:

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7. Reasons why fixed route service cannot be used:

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b. Destination and address:

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8. Reasons why fixed route service cannot be used:

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c. Destination and address:

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9. Reasons why fixed route service cannot be used:

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10. Please read the following statements and check all those that best describe what you believe about your ability to use Grand Valley Transit by yourself.

- I use Grand Valley Transit for some trips, but sometimes there are barriers that prevent me from using these services
- I use Grand Valley Transit frequently on routes to familiar destinations
- I use Grand Valley Transit to go to new places
- I believe I could use Grand Valley Transit if someone taught me
- I am not able to use Grand Valley Transit by myself
- The severity of my disability changes from day to day, I ride Grand Valley Transit when I am feeling well
- Some weather conditions prevent me from getting to and from the bus stop
- I can get to and from the bus stop if the distance is not too great
- The bus does not always go where I want to go

#### **D. YOUR FUNCTIONAL ABILITY**

Your answers to questions in this section will help us better understand your functional ability in specific areas. **For each question, please circle only one answer.** Your answers should be based on your physical and cognitive ability to perform the tasks independently using the mobility equipment that you typically use when traveling outside your home.

**Without the help of someone else, can you:**

**1. Walk up and down the steps if there are handrails on both sides?**

Always

Sometimes

Never

Not Sure

**2. Use the telephone to get information?**

Always

Sometimes

Never

Not Sure

**3. Travel one level block on the sidewalk in good weather?**

Always

Sometimes

Never

Not Sure

**4. If you are able to do this, how long does it take you?**

Less than 5 minutes    Five to ten minutes    Not Sure

**5. Cross the street, if there are curb cuts?**

Always                      Sometimes                      Never                      Not Sure

**6. Ride up and down a wheelchair lift with handrails on both sides?**

Always                      Sometimes                      Never                      Not Sure

**7. Cross the street, if there are traffic controls?**

Always                      Sometimes                      Never                      Not Sure

**8. Travel three blocks on the sidewalk in good weather?**

Always                      Sometimes                      Never                      Not Sure

**9. If you are able to do this, how long does it take you?**

Less than ten minutes    Ten to Fifteen minutes    Not Sure

**10. Step on and off a curb from a sidewalk?**

Always                      Sometimes                      Never                      Not Sure

**11. Wait ten minutes outside in good weather if there is no seat?**

Always                      Sometimes                      Never                      Not Sure

**12. Find your own way to or from transit stop after being shown?**

Always                      Sometimes                      Never                      Not Sure

**13. Currently travel by yourself using any mode of transportation?**

Always                      Sometimes                      Never                      Not Sure

**14. If always or sometimes, which modes of transportation allow you to travel independently?**

Paratransit      Grand Valley Transit      Car

**15. Have you ever gotten lost when traveling alone?**

Yes    No, I never travel outside alone    No, I've never gotten lost

**16. If yes, were you able to find your way back?**

Yes       Yes, with help       No

**17. If the weather is good and there are no environmental barriers, how far can you travel outdoors using your mobility device, if applicable.**

- I cannot travel outdoors alone at all
- Less than: 1 block       Curb in front of my house
- 3 blocks       6 blocks
- 9 blocks       More than 9 blocks
- Not sure       Other: \_\_\_\_\_

**E. WEATHER AND ENVIRONMENT**

Does the weather affect your ability to use Grand Valley Transit?

Yes       Sometimes       No

If yes or sometimes, please explain how:

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Are you able to get to and from Grand Valley Transit stops on your own?

Yes       No       Sometimes

If No or Sometimes, please check all that apply:

- I cannot get places if there are no curb-cuts
- I cannot if the street or sidewalk is too steep
- I cannot cross busy streets and intersections
- I cannot travel outside when it is too hot or too cold due to my disability
- I cannot find my way at night because of a vision disability
- I get confused and cannot find my way



- I probably could with travel training
- I feel unsafe when traveling alone on Grand Valley Transit
- Other: \_\_\_\_\_

Please use this space to tell us anything else you would like us to know about your travel challenges and your ability to use Grand Valley Transit.

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### Certifications

I certify that the information I gave in this application is true and correct. I understand that falsification of 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 those services.

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

### Person completing form if other than applicant (please check one):

- \_\_\_ I certify that the information provided in this application is true and correct, based upon information given 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.

Print Name \_\_\_\_\_  
 Signature \_\_\_\_\_ Daytime Phone \_\_\_\_\_  
 Relationship to Applicant \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_

**PROFESSIONAL AUTHORIZATION**

**THIS PAGE MUST BE COMPLETED BY ONE OF THE FOLLOWING CURRENTLY LICENSED PROFESSIONALS:** (please check one)

- |  |  |
|--|--|
| <input type="checkbox"/> Vocational rehabilitation counselor                 | <input type="checkbox"/> Psychiatrist            |
| <input type="checkbox"/> Special education teacher                           | <input type="checkbox"/> Physician's assistant   |
| <input type="checkbox"/> Speech pathologist                                  | <input type="checkbox"/> Physician               |
| <input type="checkbox"/> Social worker                                       | <input type="checkbox"/> Physical therapist      |
| <input type="checkbox"/> Respiratory therapist                               | <input type="checkbox"/> Occupational therapist  |
| <input type="checkbox"/> Registered nurse                                    | <input type="checkbox"/> Nurse practitioner      |
| <input type="checkbox"/> Psychologist  | <input type="checkbox"/> Mental health counselor |
| <input type="checkbox"/> Recreation therapist employed by a medical facility | <input type="checkbox"/> Chiropractor            |
| <input type="checkbox"/> Orientation & Mobility instructor of the blind      | <input type="checkbox"/> Travel trainer          |

**Please describe all conditions (physical, cognitive, emotional, other), which functionally prevent the applicant from using the GVT fixed routes?**

\_\_\_\_\_  
\_\_\_\_\_

**How does this condition PREVENT the applicant from using the GVT fixed route bus service?** \_\_\_\_\_

\_\_\_\_\_

Is this condition temporary?     Yes, for \_\_\_\_\_ months.     No

Exceptions or additions: \_\_\_\_\_

I certify that the information contained in parts I – V of this application is true and correct to the best of my knowledge and ability.

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

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

Clinic/Agency \_\_\_\_\_

Telephone \_\_\_\_\_

Address \_\_\_\_\_

The Americans with Disabilities Act of 1990 (ADA) is a civil rights law that bans discrimination against people with disabilities. To meet their needs, public transportation companies must provide a variety of services. The applicant may be found eligible for paratransit services for all trips he or she requests, or eligible (based on functional ability) for some trip requests but not for others, or ineligible because he or she is capable of using fixed route transit. The information you provide will enable us to make an appropriate determination for this applicant. All information will be kept confidential. Thank you for your assistance.

**FOR OFFICE USE ONLY**

Application Received

\_\_\_\_\_ Initial \_\_\_\_\_ Date

Application Complete

\_\_\_\_\_ Initial \_\_\_\_\_ Date

**APPROVAL**

Dispatch Approval - Letter sent

\_\_\_\_\_ Initial \_\_\_\_\_ Date

Review Board

\_\_\_\_\_ Initial \_\_\_\_\_ Date

Review Board

\_\_\_\_\_ Initial \_\_\_\_\_ Date

Review Board

\_\_\_\_\_ Initial \_\_\_\_\_ Date

Decline Letter Sent

\_\_\_\_\_ Initial \_\_\_\_\_ Date

Application Up-date

\_\_\_\_\_ Initial \_\_\_\_\_ Date

**PROGRAM**

Unconditional \_\_\_\_\_

Temp \_\_\_\_ Expires \_\_\_\_\_ Date

Conditional \_\_\_\_\_

Conditions \_\_\_\_\_

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