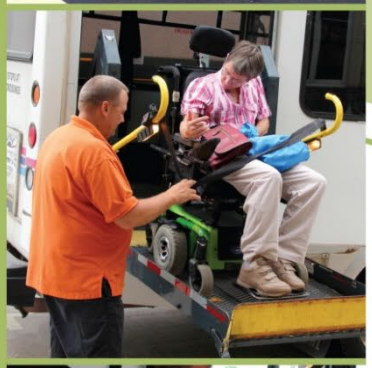
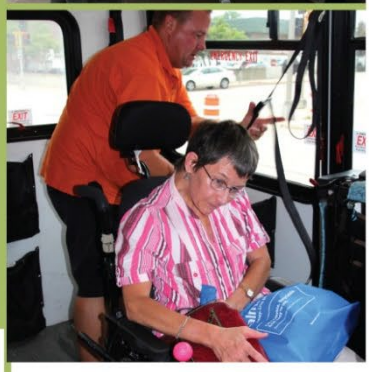
sam
sioux area metro

ADA Complementary Paratransit Bus Service

Mobility Needs Application





This packet includes:

- Paratransit Service Eligibility Information
- Paratransit Service Area Boundaries Map
- Application Instructions
- Application Form
- Certification for Personal Care Attendant
- Release of Information Authorization Form

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February 2018

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PARATRANSIT SERVICE ELIGIBILITY INFORMATION

The following forms are to be used by persons wishing to apply for eligibility for Sioux Area Metro ADA Paratransit services. Individuals with disabilities that **prevent** them from boarding, riding on, or deboarding regular route accessible SAM buses **may** qualify for this service. All Sioux Area Metro regular routes have accessible bus service.

The information obtained through the certification process will only be used by staff to determine eligibility status and to provide transportation services if eligible.

WHO QUALIFIES:

The American Disabilities Act (ADA) set rules for certification. Under these rules, there are two basic categories of people who are eligible for paratransit services. Any person with a disability is eligible **if** (Check all that apply to you):

 You, as a result of your disability are unable to board, ride, or disembark from an accessible vehicle without the assistance of another person (except for the operator of a lift or other boarding device).

 You have a specific impairment-related condition that **prevents** you from traveling to or from **any** bus stop.

If you have checked one of the boxes above, you may qualify for SAM Paratransit services.

SERVICE AREA

Under the Americans with Disabilities Act (ADA), Sioux Area Metro is required to provide paratransit services to eligible riders with an origination point and destination point within 3/4 of a mile of a fixed-route bus route. This ADA service area is outlined in yellow and orange as shown on the map on the inside back cover of this packet. If you reside outside this area, you may still be eligible for this service, but all trips must start and end within that service area. It is your responsibility to get within the service area for SAM Paratransit service.

Sioux Area Metro provides services without regard to race, color, gender, religion, national origin, age, or disability, pursuant to local, state, and federal laws.

Any person who has questions, requests for accommodation, or who believes they have been discriminated against should contact Sioux Area Metro at 605-367-7151.

Sioux Area Metro is an Equal Opportunity Employer

APPLICATION INSTRUCTIONS

If you require the application form and/or other information in another format, you may request it from Sioux Area Metro. The application is available in large print, Braille, or CD.

■ STEP 1

Please complete all information requested in this application. If you do not understand a question, please contact Sioux Area Metro staff by calling 367-7613. **Please answer all questions.** If there are any items not completed in the application, it may delay processing.

The application can be accessed at www.siouxfalls.org/paratransit.

■ STEP 2

Call 367-7613 to set up a time for an in-person interview. If you do not have transportation to the interview, Sioux Area Metro will provide you a trip, free of charge, on a paratransit bus provided that the pickup location is within the Sioux Area Metro Paratransit service area. Please allow up to two hours for the in-person interview.

■ STEP 3

Attend the in-person interview. An occupational therapist will also attend the interview to perform mobility assessments. The functional mobility assessment is completed to determine if current physical and cognitive level would allow you to ride on a fixed-route bus in some or all cases. Therefore, this mobility assessment may include a ride on a fixed-route bus with the occupational therapist. You may have someone else come along on the fixed-route bus ride if you like.

After all the information is collected, an eligibility determination will be made within 21 days.

If you disagree with your eligibility determination, you have the right to appeal the decision. This must be done in writing and sent to:

City ADA Coordinator
Human Relations
P.O. Box 7402
Sioux Falls, SD 57117-7402

If you would like to request a hearing, this must be indicated in the written request. If you require special accommodations to attend the hearing, please specify your needs in the letter.

If you are a current eligible rider and are appealing a renewal determination of your eligibility, you will continue to be eligible for paratransit service under your previous eligibility determination until a decision has been made on your appeal.

If this is your first request for paratransit service and you are appealing your determination of eligibility, your public transportation will not be provided using paratransit service while a determination is being made on your appeal. However, it is required that a decision be made on the appeal within 30 days. If it is not, temporary paratransit service will be provided to you until a decision is made.

APPLICATION

PERSONAL/CONTACT INFORMATION—PLEASE PRINT

Last Name: _____

First Name: _____ MI: _____

Address: _____ Apt.: _____

City: _____ State: _____ Zip Code: _____

Mailing address, if different than above: _____

_____

Phone Numbers:

Home: _____ Cell: _____

Work: _____ TTY: _____

Email Address: _____

Date of Birth: _____

EMERGENCY CONTACT INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Numbers:

Home: _____ Cell: _____

Work: _____

Relationship to Applicant: _____

Have you ever been eligible for ADA paratransit service in a different location?

☐ Yes ☐ No

If yes, where were you eligible? _____

Was your eligibility ☐ Unconditional ☐ Conditional

If conditional, what were your conditions? _____

_____

FUNCTIONAL LIMITATION INFORMATION

What condition is causing the functional limitations that **prevent(s)** you from using the fully accessible fixed-route bus service without the help of another person?

_____

_____

Explain **how** the functional limitations you described above prevent you from using the fully accessible fixed-route buses without the help of another person. Be specific. Attach a separate sheet of information if necessary.

_____

_____

_____

When did you first experience the limitations described above?

☐ Less than 1 year ☐ 1–5 years ago ☐ Longer than 5 years

Do the limitations you described above change from day-to-day in a way that affects your ability to use the fully accessible fixed-route buses?

☐ Yes, I could use the fully accessible fixed-route buses some days but other days I could not.

☐ No, my limitations do not change.

☐ I don't know.

Are the conditions you described?

☐ Permanent ☐ Temporary ☐ Don't know

If temporary, how long do you expect this to continue? _____ months.

MOBILITY INFORMATION

Which of the following mobility aids do you use to help you get to where you need to go? Please check all that apply.

☐ Cane
☐ White cane
☐ Walker
☐ Crutches
☐ Manual wheelchair
☐ Powered wheelchair
☐ Powered scooter/cart
☐ Portable oxygen
☐ Prosthesis
☐ None of these

☐ Service Animal (please describe): _____

☐ Other (please describe): _____

A common adult wheelchair is defined as a device that does not exceed 30 inches in width and 48 inches in length measured 2 inches above the ground, and does not weigh more than 600 pounds when occupied.

If you use a manual or powered wheelchair or scooter, does it weigh more than 600 pounds when occupied?

☐ Yes ☐ No

If you use a manual or powered wheelchair or scooter, measured 2 inches above the ground, is it more than 30 inches wide or more than 48 inches long?

☐ Yes ☐ No

If yes, please give the length and width.

Length: _____

Width: _____

OTHER INFORMATION

Please check the box that best describes your current living situation.

☐ Live independently (without the assistance of another person).

☐ 24-hour care or skilled nursing facility.

☐ Live with family members who help me.

☐ Assisted living facility.

☐ Receive assistance from someone who comes to my home to help with daily living activities.

☐ Other (please describe): _____

How far can you travel with your powered mobility device without the help of another person?

☐ Less than 1 block ☐ 3 to 6 blocks

☐ Up to 2 blocks ☐ 7 or more blocks ☐ N/A

How far can you travel with your mobility device (cane, walker, manual wheelchair, or other) without the help of another person?

☐ Less than 1 block ☐ 3 to 6 blocks

☐ Up to 2 blocks ☐ 7 or more blocks ☐ N/A

How far can you walk without the help of another person?

☐ Less than 1 block ☐ 3 to 6 blocks

☐ Up to 2 blocks ☐ 7 or more blocks ☐ N/A

How long can you wait outside for a ride? (Check only one response.)

☐ I could wait by myself for 10 to 15 minutes.

☐ I could wait by myself for 10 to 15 minutes only if I had a seat and/or shelter.

☐ I would need someone to wait with me because: _____

_____

Which of the following best describes your experience with fully accessible fixed-route buses? (Check only one response.)

☐ I have never used the fully accessible fixed-route buses.

☐ I have used the fully accessible fixed-route buses, but not since the onset of my health condition.

☐ I have used the fully accessible fixed-route buses within the last six months.

☐ Other (please describe): _____

How do you currently travel to your frequent destinations? (Check all that apply.)

☐ Buses How many times per month? _____

☐ Paratransit How many times per month? _____

☐ Taxi How many times per month? _____

☐ Drive myself How many times per month? _____

☐ Someone drives me How many times per month? _____

☐ Other: _____

What is the closest bus stop to your residence? Please give the location (such as corner of 12th Street and Western Avenue). Please note eligibility is not determined by location.

_____

Can you travel to and from the bus stop nearest your residence without the help of another person?

☐ Yes ☐ No ☐ Sometimes ☐ Don't know where the stop is

If no or sometimes, check why.

☐ Hills ☐ Curbs ☐ No sidewalks ☐ Weather

☐ Street crossings

☐ Other: _____

Please answer the following questions as they relate to the functional limitations you have:

Can you grip railings and handles?	☐ Yes	☐ No	☐ Sometimes
Can you balance while seated?	☐ Yes	☐ No	☐ Sometimes
Are you able to cross streets with traffic lights?	☐ Yes	☐ No	☐ Sometimes
Are you able to cross streets with no traffic lights?	☐ Yes	☐ No	☐ Sometimes
Are you able to cross streets at a busy intersection?	☐ Yes	☐ No	☐ Sometimes
Can you ask for and understand directions?	☐ Yes	☐ No	☐ Sometimes
Can you deal with unexpected situations or changes to your routine?	☐ Yes	☐ No	☐ Sometimes
Can you safely and effectively travel through a crowd?	☐ Yes	☐ No	☐ Sometimes
Do you need a lift or ramp to board the bus?	☐ Yes	☐ No	☐ Sometimes

Please add any other information that you would like us to know about your functional limitations.

_____

_____

_____

Are you eligible for South Dakota Medicaid? ☐ Yes ☐ No

If yes, please provide your Medicaid number: _____

PERSONAL CARE ATTENDANT (PCA) INFORMATION

Some of our customers require the assistance of a PCA. A PCA is someone who regularly assists the customer. When the customer travels, the PCA performs personal duties that drivers are not allowed to do. Some of these duties may include, but are not limited to:

1. Guiding a child or adult with an intellectual or developmental disability.
2. Assisting a customer diagnosed with Alzheimer's or Dementia.
3. Directing a customer who is unable to travel independently.
4. Calming a customer who tends to become upset in unexpected situations.
5. Preventing a customer from leaving his/her seat or opening a door when the vehicle is in motion and/or.
6. Assisting a customer with managing schedule and trip commitments in order to prevent excessive missed trips and potential suspensions of SAM Paratransit service.

We strongly suggest that customers who are authorized to travel with a PCA, and who need a PCA to perform some of the duties mentioned previously, always travel with a PCA on Paratransit trips. The customer's SAM Paratransit ID will note "YES" next to Personal Care Attendant. Please tell a reservationist when a PCA will be traveling with you. **Remember:** SAM Paratransit does not have staff to monitor or supervise its customers.

A SAM Paratransit vehicle is just like a city bus, except that it transports its customers door-to-door. If you think it's unsafe to let your family member or the individual you assist travel alone on a fixed-route bus, you should not let her/him travel alone on a SAM Paratransit bus.

CERTIFICATION FOR PERSONAL CARE ATTENDANT

Applicant Name: _____

Do you require a PCA?

☐ Yes, always ☐ Sometimes ☐ No

Note: If answered "no," anyone riding along will be a fare-paying guest. If answered "yes, always," you will not be allowed to ride without a PCA.

VERIFICATION

I certify that due to my functional limitation, I require the services of a Personal Care Attendant to assist and travel with me on Sioux Area Metro Paratransit bus service. **I understand that fraudulently claiming to travel with an attendant to avoid paying a fare for a companion may result in suspension of service.**

Signature: _____

Date: _____

SIOUX AREA METRO PARATRANSIT CERTIFICATION AS UNATTENDED OR SUPERVISED PASSENGER

This certification is to determine for SAM Paratransit services whether a SAM Paratransit passenger is categorized as a supervised passenger or as an unattended passenger based on one or more of the following:

1. Age.
2. Cognitive limitation.
3. Special request of the responsible party.

Do you authorize Sioux Area Metro Paratransit to leave you unattended at the destination of a Sioux Area Metro Paratransit bus ride? ☐ Yes ☐ No

If you answered yes, you have then indicated that it is okay to be **unattended** at the destination of your trip. If that is accurate, please sign below. This will be included as a part of your Sioux Area Metro Paratransit eligibility documentation.

Name (Printed): _____

Address: _____

Signature: _____

If you answered yes, STOP HERE.

If no, then you want Sioux Area Metro Paratransit to ensure that you are **supervised** at the destination of your trip. Please complete all of the information below and sign on the next page.

Passenger Name (Printed): _____

Address: _____

Legal Guardian (if applicable): _____

Phone Number: _____

Attendant (who will be at the origin and destination of the trip).

Name: _____ Phone Number: _____

Emergency Contact: _____ Phone Number: _____

As passenger or legal guardian, explain why you or the passenger is unable to be left unattended and therefore must be supervised at either the origin or destination of Sioux Area Metro Paratransit bus ride.

_____

_____

_____

_____

Are there any address locations where it would be acceptable for Sioux Area Metro Paratransit to leave you unattended? ☐ Yes ☐ No

Address: _____

Is this address your home? ☐ Yes ☐ No

VERIFICATION FOR **REFUSAL** OF UNATTENDED STATUS:

I certify that due to my functional limitation, I am not able to be left unattended before or after my ride on Sioux Area Metro Paratransit buses and that I will make arrangements to have the above-listed attendant meet the Paratransit vehicle at the origin and destination of each ride that I take. In addition, I verify that I agree to the below statements:

1. I understand that the driver will only wait five minutes for my responsible party to meet the Sioux Area Metro Paratransit vehicle.
2. I understand if no one arrives, the driver will notify the Sioux Area Metro Paratransit offices and continue on their route with the passenger still on board. The Sioux Area Metro Paratransit office will attempt to reach the designated emergency contact person.
3. I understand if I am not met by the end of the route, I will be returned to the bus garage and at that time, the South Dakota Department of Social Services (during business hours) or local law enforcement (during all other hours) will be notified to assist in locating my designated emergency contact.
4. I understand that, if I travel on a route beyond my scheduled destination because of my unattended status, I may be subject to suspension of services.
5. I understand that Sioux Area Metro Paratransit drivers do not have specialized training required by nursing homes, assisted living centers, day habilitation programs, or prevocational programs to help during ride services.
6. I understand drivers only have training in first aid, passenger assistance, abuse prevention, and defensive driving and that the driver is only responsible for safely securing and transporting me.
7. I understand that it is not unusual for the driver to leave the vehicle unattended for short periods while assisting another passenger to the door.
8. I understand, that this will be included as a part of my Sioux Area Metro Paratransit eligibility documentation.

Signature of Applicant: _____

Signature of Legal Guardian on behalf of applicant (if applicant is not legally authorized to sign:

_____

Date: _____

CORRESPONDENCE

Preferred Language:

☐ English ☐ Spanish

☐ Other (specify): _____

In what format would you prefer your response to this application?

☐ Written ☐ Braille ☐ Large print ☐ Audio tape or CD

SIGNATURE

I, the applicant (and guardian), understand that the purpose of this application form is to determine my eligibility to use the Sioux Area Metro Paratransit bus service. I hereby certify that the information given in this application is true and correct. If contact information, medical information, or functional limitations should change, I agree to contact Sioux Area Metro Paratransit with updated information. I understand the information contained herein will be treated confidentially, and that Sioux Area Metro Paratransit reserves the right to request additional information.

_____

Signature of Applicant

_____

Date

_____

Signature of Parent or Guardian (if applicant is under 18)

_____

Signature of Preparer (if other than applicant)

_____

Printed Name of Preparer

_____

Date

In order to allow Sioux Area Metro to evaluate your request for ADA paratransit service eligibility, it may be necessary to contact a health care or rehabilitation professional for additional information about your disability and your ability to use a regular fully accessible bus. This should be the medical professional most familiar with your disability and functional limitations and the professional who understands your ability or inability to travel on a regular fully accessible bus.

Please complete and sign the following authorization.

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RELEASE OF INFORMATION AUTHORIZATION FORM

I authorize the following professional to release to Sioux Area Metro information about my disability and its effect on my ability to travel. This information may be needed in the evaluation of my request for ADA paratransit service. It is my understanding that the information released will be used solely to determine my ADA paratransit service eligibility. I understand that I may revoke this authorization at any time. Unless earlier revoked, this form will permit the professional listed to release the information described until 120 days after the date below.

Name of Professional: _____

Medical Facility or Clinic: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Fax Number: _____

Applicant's Name: _____

Applicant's Signature: _____

Date Signed: _____

PARATRANSIT SERVICE AREA BOUNDARIES