Hayward Operated Paratransit (The HOP)
A Measure BB funded Paratransit Program
Designed to Supplement and Complement the East Bay Paratransit Service System

APPLICATION INFORMATION

Thank you for inquiring about the Hayward Operated Paratransit (The HOP) program. **East Bay Paratransit** is the primary ADA mandated paratransit service for Hayward and Alameda County. *If under the age of 70, you must also apply to East Bay Paratransit (the County provider) in order to enroll with Hayward.* If you have already applied with EBP, please submit a copy of your letter of eligibility or letter of denial of services.

Hayward Operated Paratransit Application: All riders must complete an application form. In lieu of a letter of approval from EBP, applicants under 70 must submit a Medical statement form **must be completed by a medical professional**. If you are 70 years or older, the medical statement is not required.

Completed forms should be returned to:

Mail: Hayward City Hall
Paratransit Program
777 B Street, 4th Floor
Hayward CA 94541
Email: paratransit@hayward-ca.gov
Fax: (510) 583-3650

If you have any questions regarding the enclosed information, please feel free to call our office at (510) 583-4230.

Hayward Operated Paratransit Program
Medical Statement Form

This form may need to be completed if the applicant does not meet the "Senior" age (70+) eligibility requirement of the Hayward Operated Paratransit service for which they are applying. For more information, please refer to the hayward-ca.gov/residents/paratransit or call the program directly.

Applicant's Name: _____ Birthdate: _____
Address: _____

Dear Physician, Social Worker, or Health Care Professional:

The above-named person is applying for the paratransit services in the city where they reside. In order to determine whether this applicant is eligible for paratransit services, applicant must provide verification that they are unable to utilize public transit services independently due to a disability/disabling health condition. All information provided below is confidential and is used for the sole purpose of establishing eligibility for paratransit services. Please help us determine the eligibility status of this individual by checking and/or completing all of the items below that apply to applicant. Please return this form to the applicant to submit with their paratransit application. Thank you.

I. Please describe the applicant's disability or disabling health condition that prevents use of public transit (i.e., buses and/or BART): Please attach additional pages if needed

_____
_____

II. Applicant's condition is: □ Permanent □ Temporary until (date): _____

III. Due to the conditions noted above, applicant is unable to use public transit services because they:

a. _ Cannot walk or travel in a wheelchair or scooter to or from a bus or train stop without the help of another person
b. _ Cannot board or get off a bus or train without the help of someone else
c. _ Cannot wait outside by him/herself for a bus or train to arrive
d. _ Cannot stand and maintain balance on a moving public transit vehicle
e. _ Cannot see, read and/or comprehend information signs, schedules, maps, etc.
f. _ Cannot hear and/or comprehend verbal information given by public transit personnel
g. _ Other reason(s): _____

IV. Are paratransit services needed for applicant to obtain life-sustaining treatment? □ Yes □ No
(i.e., dialysis, chemotherapy, radiation therapy, etc.)

PRACTITIONER'S STATEMENT: *I hereby state that the information provided above is correct.*

Practitioner's Name: _____ _____
(Print/Type) (Signature)

Date: _____ Discipline: □ Physician □ Nurse □ Social Worker
□ Other Practitioner (describe): _____

Agency/Organization Affiliation: _____
Address: _____

Telephone #: _____ Fax #: _____ Email: _____

RETURN TO:	Hayward Operated Paratransit Program 777 B Street, 4th Floor, Hayward CA 94541 Tel: (510) 583-4230 | Fax: (510) 583-3650 Email: paratransit@hayward-ca.gov

(rev. 03/17/2023)

Paratransit Application Form (rev. 03/17/23)

Name: _____ | _____ | _____
Last Name | First Name | Middle Initial

Daytime Phone: (____) ____ - ____ **Cell Phone:** (____) ____ - ____

TTT/TTY Phone: (____) ____ - ____ **Email:** _____

Home Address: _____ | ____ | _____ | ____
Street Address | Apt. # | City | Zip Code

Mailing Address: _____ | ____ | _____ | ____ | ____
(If different from above) Street Address or PO Box | Apt. # | City | State | Zip Code

Name of Housing Facility (if applicable): _____

Birth Date: ____ / ____ / ____
(MM/DD/YYYY) Month Day Year

What is your race/ethnicity? ***(Check all that apply)*** ☐ Caucasian ☐ African American
☐ Asian/Pacific Islander ☐ Hispanic/Latino ☐ Native American ☐ Other_____

1. **Have you been certified as eligible for rides with an ADA paratransit service?**
(i.e. East Bay Paratransit, Wheels Dial-A-Ride, Union City Paratransit)
☐ Fully eligible ☐ Conditionally eligible **EBP Rider Identification #:**_____
☐ Not eligible/Denied ☐ Have not applied or **Interview Date:**_____

2. **Do you use any of the following mobility aids or specialized equipment?** ☐ **No**
☐ Cane ☐ White Cane ☐ Walker
☐ Manual Wheelchair ☐ Power Wheelchair ☐ Power Scooter
☐ Service Animal ☐ Portable Oxygen Tank ☐ Other: _____

3. **Do you need a wheelchair lift to get in and out of a vehicle?**
☐ Yes ☐ No ☐ Don't know

4. **Do you typically travel with assistance from another person?** ☐ Yes ☐ No

5. **Please describe your disability or disabling health condition and explain how this condition prevents you from using public transit** (i.e. buses or BART)**:**

_____

_____

6. **Is the above condition you describe:** ☐ Permanent ☐ Temporary until:_____

7. **How often do you expect to use paratransit?** ☐ Daily ☐ 2-4x week ☐ 2-4x month

For Office Use Only: Client # _____

the HOP
Hayward Paratransit
TRANSPORTATION FOR THE ELDERLY & DISABLED

8. **How do you currently travel to your most frequent destinations? (Check all that apply)**
   ☐ ADA Paratransit (i.e. East Bay Paratransit)
   ☐ Drive myself ☐ Someone drives me ☐ Bus/BART ☐ Taxi ☐ Uber/Lyft
   ☐ Other: _____

9. **Are you on any of the following forms of income/benefit assistance?** ***(check all that apply)***
   ☐ **Supplemental Security Income (SSI)** ☐ **Medi-Cal** ☐ **CalWorks**
   ☐ **General Assistance (GA)** ☐ **Cash Assistance Program for Immigrants (CAPI)**

10. **Gross *Individual* Monthly Income:** _____

11. **Gross *Household* Monthly Income:** _____ **# of people in household**: ____

12. **Would you like help learning to use paratransit?** ☐ **YES** ☐ **NO**

13. **Would you like help with appointments or running errands?** ☐ **YES** ☐ **NO**

14. **What is your living arrangement?** ☐ Live alone ☐ Live w/ spouse/partner
    ☐ Live with adult children ☐ Live in a skilled nursing facility/nursing home
    ☐ Live in assisted living/residential care home ☐ Other: _____

15. **What language(s) do you speak?** Preferred Language: _____
    Other Language(s): _____

Emergency Contact Person: _____

Relationship to you: _____ Daytime phone: (____) _____

Cell phone: (____) _____ Email: _____

Do you manage your own affairs and deal with your own mail? ☐ Yes ☐ No

If "No," to whom should correspondence be mailed?

Name: _____ Relationship: _____

Phone: (____) _____ Email _____

16. **If you need future information provided to you in an accessible format, please check which format you prefer:** ☐ Large Print ☐ Audiotape ☐ Braille ☐ Electronic File

17. **Do you (or your care giver) wish to receive your introduction packet and future changes by e-mail?** (Please note vouchers will still be mailed to you)**:**
    ☐ Yes ☐ No ***If "Yes", please provide your (or your care giver's) e-mail address so we can send you the information** _____

I certify that the information in this application is true and correct. I understand that knowingly falsifying the information will result in denial of service. I give the City permission to verify whether I am enrolled with East Bay Paratransit. I understand that all application information will be kept confidential, and only the information required to provide the service I request will be disclosed to those who perform the services.

*Applicant's Signature: _____ *Date: _____

Name of Person who assisted you with application/Phone #: _____

For Office Use Only: Client # _____