



City of Hayward (Measure B) Paratransit Program
*A Program Designed to Supplement and Complement the
East Bay Paratransit Service System*

APPLICATION INFORMATION

Thank you for inquiring about the City of Hayward Paratransit Program. Enclosed are two forms.

- ◆ One form is the **Paratransit Program Application Form**, which **you should complete**.
- ◆ The second form is a **Paratransit Program Medical Statement Form**, which **must be completed by a medical professional**. However, if you are 80 years old or older, you do not need to have the Medical Statement form completed. You need to complete only the application form.

Completed forms should be returned to:

**Hayward City Hall - Paratransit Program
777 B Street, Hayward, CA 94541**

Completed forms may also be faxed to the attention of the Paratransit Program at: **FAX: (510) 583-3650**

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

Department of Library and Neighborhood Services
Neighborhood Services Division

777 B Street, Hayward, CA 94541-5007
Tel: 510/583-4250 Fax: 510/583-3650

City of Hayward
Paratransit Program Medical Statement Form

Dear Physician:

The person named below would like to participate in the City of Hayward Paratransit Program. This is a transportation service designed for those unable to utilize other public transit services. In order for the application to be complete, a medical certification form describing the person's functional transportation limitations is required. All information provided below is confidential and is used for the sole purpose of establishing eligibility for the City of Hayward Paratransit Program. Please help us to determine the certification status of this individual by providing the information required.

Applicant's Name _____

Med. Ins. Coverage _____ Med Ins. # _____

- ***Please check all of the items below which apply to this applicant***

I. *Because of a medical and/or disabling condition, the above named person is unable to :*

- A. _____ Get to a fixed route or wheelchair lift equipped transit service (ex: bus, BART).
- B. _____ Board from a standard public transit vehicle (ex: bus, BART).
- C. _____ Wait for, or stand in, a moving transit vehicle (ex: bus, BART).
- D. _____ See, read and/or comprehend information signs, schedules, maps, etc.
- E. _____ Hear and/or comprehend verbal information given by a public transit personnel.
- F. _____ Get to, in and out of a taxi vehicle without assistance.
- G. _____ Use regular public transportation services because: _____
- H. _____ Drive an automobile. When will the applicant be able to drive again?(date)_____
- I. _____ Use East Bay Paratransit services because: _____

II. *Nature of applicant's condition:*

- A. Diagnosis: _____
Is this applicant's condition: permanent? _____ temporary? _____ If temporary, for how long? _____
- B. Does the above named applicant use a wheelchair? YES _____ NO _____
- C. Does the person use other assistive devices to ambulate or mobilize? (describe) _____
- D. Are paratransit services needed by the above named person to obtain a ***life sustaining treatment?***
(ex: dialysis, chemotherapy, radiation therapy, etc.) YES _____ NO _____
- E. If doctor's visits are required: How often? _____ Until when? (date) _____
- F. If therapy is required: How often? _____ Until when? (date) _____

III. *Physician's Statement:*

I hereby state that the information provided above is correct.

Date _____

Physician's Name: Print- _____

Signature- _____

Address: _____

Telephone No. _____ Fax No. _____

RETURN TO:

City of Hayward

777 B Street

Hayward, CA 94541

Tel: (510) 583-4230 Fax: (510) 583-3650

Paratransit Application Form (rev. 8/3/09)

For Non-ADA Paratransit Services. Please use if you are a resident of: *Alameda, Albany, Berkeley, Castro Valley, Emeryville, Fremont, Hayward, Newark, Oakland, Pleasanton, San Leandro or San Lorenzo*

Name: _____
Last Name First Name Middle Initial

Daytime Phone: (____) _____ Cell Phone: (____) _____

Evening Phone: (____) _____ TDD/TTY: (____) _____

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

Name of Housing Facility (if applicable): _____

Birth Date: ____/____/____ Male Female
Month Day Year

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

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

Name: _____ Relationship: _____

Daytime phone: (____) _____ Cell or Evening phone: (____) _____

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

Do you (or your care giver) wish to receive your introduction packet and future changes by e-mail? (Please note vouchers and your round-about pass 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:

1. Are you on any of the following forms of income/benefit assistance? (check all that apply)

- Supplemental Security Income (SSI) Medi-Cal General Assistance (GA)
 Cash Assistance Program for Immigrants (CAPI) CalWorks

2. Gross Individual Monthly Income: _____

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

4. **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: _____

5. **What is your race/ethnicity?**

- African American Asian/Pacific Islander
 Caucasian Hispanic/Latino Native American
 Other: _____

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

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

- ADA Paratransit (i.e. East Bay Paratransit, Wheels Dial-A-Ride, Union City Paratransit)
 Drive myself Someone drives me Buses/BART Taxi
 Other: _____

8. **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 **Rider Identification #:** _____
 Not eligible/Denied Have not applied Don't know

9. **Do you use any of the following mobility aids or specialized equipment?**

- Cane White Cane Walker
 Manual Wheelchair Power Wheelchair Power Scooter
 Service Animal Portable Oxygen Tank Other: _____

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

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

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

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

14. **Emergency Contact Person:** _____

Relationship to you: _____ Daytime phone: (_____) _____
Cell phone: (_____) _____ Evening phone: (_____) _____

15. If you need future information provided to you in an accessible format, please check which format you prefer:

Large Print Audiotape Braille CD/Electronic File

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, Wheels Dial-A-Ride or Union City 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: _____

Person who assisted you with application/Phone #: _____