Hayward Operated Paratransit (The HOP)
A Measure B/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. *You must submit a separate application to East Bay Paratransit (the County provider) and obtain an interview date in order to enroll with Hayward.* East Bay Paratransit will schedule your interview and arrange your travel if necessary. Provide a copy of your East Bay Paratransit interview confirmation letter within 30 days of receipt. 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. Medical statement forms are required for riders 18-69 and **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

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 person 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: _____ Phone # _____ Fax # _____

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

For Office Use Only: Client # _____

Paratransit Application Form (rev. 05/07/21)

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: ____ / ____ / ____ ☐ **Male** ☐ **Female**
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?**
☐ 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, Wheels Dial-A-Ride, Union City Paratransit)
☐ Drive myself ☐ Someone drives me ☐ Buses/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 ☐ CD/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, 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: _____

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

For Office Use Only: Client # _____

Referral Form

Do you know of a family member or friend who could benefit from more information regarding the Hayward Operated Paratransit program?

Name: _____ | _____
Last Name First Name

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): _____

Our team can provide information regarding the following services:

- Same-Day Transportation
- Pre-scheduled door-through-door Transportation
- Mobility Management and Travel Training
- Group Trips
- Meal Delivery
- Means-Based Fare Program

For Office Use Only: Client # _____