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. You must complete and return this application in order to enroll. Attached are two forms: **Medical Statement Form** and **Paratransit Application Form**.

The **Medical Statement Form must be completed by a medical professional.** Medical statement forms are required for riders 18-69 years of age. If you are 70 years or older, the medical statement form does not need to be completed. You need to complete only the Paratransit Application Form.

Completed forms should be returned to:

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

NOTE: **East Bay Paratransit** is the primary ADA mandated paratransit service for Hayward and Alameda County. You must apply directly to East Bay Paratransit to enroll. Call 1-800-555-8085 for more information.

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

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: _____ Phone # _____Fax # _____

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

Paratransit Application Form (rev. 7/13/11)

Please complete all questions marked with an asterisk (*).

***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 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 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 <u>and</u> 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. **How often do you expect to use paratransit?** ___ Daily ___ 2-4x week ___ 2-4x month

15. ***Emergency Contact Person:** _____
Relationship to you: _____ *Daytime phone: (____)_____
Cell phone: (____)_____ Evening phone: (____)_____

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

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 #: _____