



# APPLICATION FOR CITY OF ELK GROVE E-VAN PARATRANSIT SERVICE

The City of Elk Grove's ADA Paratransit **e-van** is a "Safety Net" for people with physical, cognitive or visual disabilities that are functionally unable to independently use the fixed-route service either all of the time, temporarily, or only under certain circumstances.

**Eligibility Certification is conducted at:  
City of Elk Grove, Transit Services  
8401 Laguna Palms Way  
Elk Grove, CA 95758  
PHONE: 916-627-3555/FAX: 916-627-4804**

## Steps in the Eligibility Process

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1. Complete the Paratransit Application that follows this page.
2. Mail or fax your signed and completed application and Professional Verification statement from your healthcare provider when required to: ***City of Elk Grove Transit Services, Attn: ADA Certification, 8401 Laguna Palms Way, Elk Grove, CA 95758 or Fax to 916-627-4804, Attn: Transit Services. An incomplete application will be returned and will delay processing.***
3. You may be asked to attend an in-person interview. Your eligibility will be determined within 21 days from the date you complete your telephone and/or in-person interview and functional assessment. You will be notified by letter as to your eligibility status.
4. If you do not receive written notice of the City of Elk Grove's decision within 21 days, you may request paratransit services until a decision has been made by calling (916) 627-3555



Please complete all sections of this form. **All information will remain confidential.**

**PART A - APPLICANT INFORMATION (PLEASE PRINT)**

**New Application** or  **Recertification**

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Last Name \_\_\_\_\_

Street Address \_\_\_\_\_ Apt# \_\_\_\_\_

Apt. Complex/Care Facility \_\_\_\_\_  
*(if applicable)*

Mailing Address \_\_\_\_\_  
*(if different from street address)*

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Phone (daytime) \_\_\_\_\_ (evening) \_\_\_\_\_

Cellular # \_\_\_\_\_ TTY for hearing impaired \_\_\_\_\_  
*(if applicable)*

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female  
Month Day Year

**Please send me written information in an alternate format.**

Large Print  Audio Tape  Braille  CD  Other: \_\_\_\_\_

**Please provide the name of a LOCAL relative/friend in case of an emergency:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone (daytime) \_\_\_\_\_ (evening) \_\_\_\_\_



## PART B - FUNCTIONAL INFORMATION

How do you travel now? Please check all that apply to you.

- walk       drive a car       ride in someone's car       taxi       bicycle  
 *e-tran*       *e-van*       RT bus/light rail train       Other: \_\_\_\_\_

What types of disabilities cause you to be unable to use the accessible fixed-route buses and light rail trains?

- physical disability       visual impairment/blindness       developmental disability  
 mental illness       recent surgery       other \_\_\_\_\_

Diagnosed when: \_\_\_\_\_ Stable or Progressive: \_\_\_\_\_

Is your disability temporary?

- Yes, I expect it to last \_\_\_\_\_ months.  
 No, it is permanent.  
 I don't know.

Do you need to travel with someone who will assist you with your trip?

- No       Yes       Sometimes

Please explain when you need the help of another person to make your trip:

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Can you maintain balance while seated on a moving vehicle?

- Yes       No

How far can you go on level ground (with your mobility aid, if you use any)?

- Up to 1 block       2 blocks       3 blocks       4 or more blocks

Are you able to climb three (3) 12" steps using a handrail?

- Yes       No       Only with great difficulty

## PART C - CURRENT USE OF ACCESSIBLE FIXED-ROUTE BUSES & LIGHT RAIL

Have you ever used the fixed route bus system (Examples- e-tran or Sacramento Regional Transit)?

Yes  No *If yes, how often? \_\_\_\_\_*

Yes, I used to but stopped because \_\_\_\_\_

No, I have never tried because \_\_\_\_\_

## PART D - MOBILITY AID AND/OR EQUIPMENT INFORMATION

Which of these mobility aids do you use? Please check all that apply to you.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> white cane     | <input type="checkbox"/> powered wheelchair*     | <input type="checkbox"/> walker           |
| <input type="checkbox"/> support cane   | <input type="checkbox"/> 3-wheel scooter/cart*   | <input type="checkbox"/> walker with seat |
| <input type="checkbox"/> crutches       | <input type="checkbox"/> manual wheelchair*      | <input type="checkbox"/> portable oxygen  |
| <input type="checkbox"/> leg brace      | <input type="checkbox"/> power assist wheelchair | <input type="checkbox"/> prosthesis       |
| <input type="checkbox"/> service animal | <input type="checkbox"/> communication board     | <input type="checkbox"/> no mobility aid  |
- other (*please specify*) \_\_\_\_\_

\* "Wheelchair" means a three or more wheeled mobility device.

Is your mobility device oversized?

Yes  No  Does not apply

If yes, please explain \_\_\_\_\_

Does your mobility device weigh less than 800 pounds when occupied?

Yes  No

Do you know how much you and your wheelchair weigh together?

Yes  No

If yes, please provide the total weight: \_\_\_\_\_ lbs

Can you transfer from your mobility device into a passenger seat?

Yes  No



**PART E - APPLICANT CONDITION DETAIL**

Please explain what and how your disability or health-related condition prevents you from using public transit – please be specific. Do not use acronyms.

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**PART F - CERTIFICATION OF APPLICANT**

I understand the information I provided on this application is true and correct to the best of my knowledge. The purpose of this application is to determine if I am eligible to use **e-van** Paratransit services, or if at times I can ride the fixed-route buses and light rail trains. I understand that falsification of information could result in a loss of **e-van** Paratransit services as well as a penalty under the law.

I also understand that, at no expense to me the City of Elk Grove may require that I participate in an in-person functional evaluation of my travel skills and agree to such a functional evaluation if one is necessary.

I agree to notify the City of Elk Grove if my condition changes, if my mobility device has been replaced, if I have a new mobility device, or if I no longer need to use **e-van** Paratransit service.

\_\_\_\_\_ Date \_\_\_\_\_  
**(Signature of Applicant or Guardian if Applicable)**

**Person Completing Application *If Not* the Applicant:**

Printed Name \_\_\_\_\_ Relationship to Applicant \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Daytime Phone # \_\_\_\_\_ Evening Phone # \_\_\_\_\_



**PROFESSIONAL VERIFICATION (REQUIRED)**

**To The Applicant -** Please have this page completed before mailing your application to the City. Any one of the professionals listed below may sign the application. If the signature page is not signed by one of these professionals, the application will be returned to you, and completion of your ADA eligibility evaluation will be delayed.

**To the Professional -** Please check your professional title:

- physician                    physician’s assistant                    registered nurse/nurse practitioner
- psychiatrist                    psychologist                    case/resource manager
- chiropractor                    physical therapist                    occupational therapist
- special education teacher                    certified speech therapist
- vocational rehabilitation counselor                    certified orientation & mobility specialist

The ADA regulations state that persons are eligible for **e-van** paratransit service if, because of a disability or medical condition, they are physically or cognitively unable to (not discomforted by or find difficult) independently using lift-equipped public transit service. Depending on their disability, people can be eligible sometimes, or all of the time. ADA **e-van** paratransit eligibility is not based on the person’s lack of knowledge of bus service, distance from bus service, ability to drive, discomfort with riding the bus, language ability, or age. The information you provide will help determine under what circumstances this applicant’s disability causes him/her to be unable to travel using lift-equipped buses or light rail trains and therefore would need to travel using a shared-ride **e-van** paratransit service.

**NAME OF APPLICANT:** \_\_\_\_\_

**Please describe the medical diagnosis, physical or cognitive disability which causes the applicant to be unable to independently use a lift-equipped bus or light rail train some, or all of the time:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Is this condition temporary?**  No     Yes for:    4 mos    6 mos    9 mos    12 mos

**This person**  is             is not able to self-supervise daily activities

**Last date of face-to-face contact with this applicant was** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

I certify under penalty of perjury under the laws of the State of California that the information contained in this application is true and correct.

Signature \_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Printed Name \_\_\_\_\_ Phone \_\_\_\_\_

Clinic/Agency \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**If Applicable:** Professional License/Registration/Certification# \_\_\_\_\_ State \_\_\_\_\_