Applying for
START Bus ADA Paratransit Service:

The Americans with Disabilities Act (ADA) requires public transit agencies that provide fixed-route service to provide "complementary paratransit" service to people with disabilities who cannot use the fixed-route bus service because of a disability.

ADA complementary paratransit service must be provided within a corridor ¾ of a mile on either side of a fixed-route bus service at the same hours and days as the fixed-route service is provided.

Paratransit service is designed for individuals whose disability or disabling condition prevents them from using accessible fixed route bus service or accessing the fixed route bus system because of their disability.

ELIGIBILITY CAN BE DETERMINED BY ONLY THREE CATEGORIES: (USDOT 37.123)

1. **UNABLE TO UNDERSTAND HOW TO COMPLETE BUS TRIPS DUE TO A COGNITIVE DEFICIENCY.**
2. **REQUIRE A LIFT-EQUIPPED BUS AND THE BUS YOU NEED DOES NOT HAVE A LIFT. (DOES NOT APPLY IN JACKSON AREA.)**
3. **UNABLE TO INDEPENDENTLY GET TO AND FROM A BUS STOP OR CANNOT GET ON AND OFF THE BUS. (LIFT CAN BE UTILIZED BY AMBULATORY.)**

1. To apply for paratransit service, complete this application and *save this page* for your reference.
2. Please complete and sign the Medical Verification Form (pages 8 - 9) as we may contact your medical provider for further information.
3. Mail both parts of the *completed* forms (6 pages) to Town of Jackson / START Bus at:

Town of Jackson / START Bus

Mailing address:
PO Box 1687
Jackson, WY 83001

Physical address:
55 Karns Meadow Drive,
Jackson, WY 83001

Or scanned and emailed to:

info@startbus.com

All determinations are made based on the information gathered from your application and medical verification form. Applicants who wish to appeal their eligibility determination will be provided with information on how to make an appeal when their assessment results are mailed.

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SOUTHERN TETON AREA RAPID TRANSIT
APPLICATION FOR ADA PARATRANSIT

If you are a first-time applicant: **If you are re-applying for services:**

☐ **New** admin only (_____) ☐ **Recertification (ID #_____)**

Name _____
Last First Middle Initial

Address _____ **Apt** _____

Name of Apartment Complex or Facility _____

City _____ **County** _____ **State** _____ **Zip** _____

Primary phone: (_____)_____-_____☐home ☐cell ☐work

Secondary phone: (_____)_____-_____☐home ☐cell ☐work

Birth Date:_____ ☐Male ☐Female ☐Self-identify _____

E-Mail: _____

Mailing Address (if different):

Address _____ Apt _____

City _____ County _____State _____ Zip _____

Primary language: _____ Will you need translation? ☐Yes ☐No

If yes, how can we assist? _____

If you will need future written information in a different format, please let us know your preference: _____

Local Emergency Contact:

Name _____Relationship _____

Primary phone: (_____)_____-_____☐home ☐cell ☐work

Secondary phone: (_____)_____-_____ ☐home ☐cell ☐work

Name/relationship of person assisting with completion of this form: _____

Why are you applying for ADA service?

_____

_____

How do you currently travel?

☐ Drive myself ☐ Cab ☐ ADA
☐ Someone drives me ☐ Bus ☐ Other
☐ Uber/Lyft

What is the closest major intersection to your home?

_____

How far is the nearest bus stop from your home? _____

Are you able to travel to this bus stop? ☐ Yes ☐No

If no, what prevents you from doing so? _____

When did you last use the fixed route bus? _____

Where do you currently go and how do you get there? _____

_____

If you no longer use fixed route service, please explain why.

_____

_____

Do you need assistance for the following when you travel?

Getting to/from bus stops:	☐ Always	☐ Never	☐ Sometimes _____
Getting on/off a bus with accessibility features (ramp/lift):	☐ Always	☐ Never	☐ Sometimes _____
Knowing where you need to go:	☐ Always	☐ Never	☐ Sometimes _____

Which of the following mobility aids do you use when you take trips using public transportation? (Please check all that apply)

☐ None	☐ Power wheelchair	☐ Prosthesis
☐ Cane	☐ Power scooter	☐ Walker
☐ Long White cane	☐ Extra-large wheelchair	☐ Crutches
☐ Portable oxygen	☐ Communication board	☐ Other: _____
☐ Manual wheelchair	☐ Service animal	

Which disability or health-related conditions PREVENT you from using regular public transit <u>without the help of another person</u>?

_____

_____

When did you first experience the conditions described above?
☐ 0-1 years ago ☐ 1-5 years ago ☐ more than 5 years ago

Are these conditions: ☐ Permanent ☐ Temporary (if so, for how long?) _____

Are the effects of these conditions variable from day to day? ☐ Yes ☐ No

Do the health-related conditions listed above inhibit your ability to perform self-care tasks or tasks related to living independently? ☐ Yes ☐ No

Are you able to:

Read a bus schedule?	☐ Yes	☐ No
Contact START to consult with trip planning?	☐ Yes	☐ No
Wait 15 min at a bus stop when standing?	☐ Yes	☐ No
Wait 15 min at a bus stop when sitting?	☐ Yes	☐ No
Determine bus fare?	☐ Yes	☐ No
Hand the fare/pass to the bus operator?	☐ Yes	☐ No
Use a mobile device to scan your digital fare?	☐ Yes	☐ No
Find a seat on the bus?	☐ Yes	☐ No

Recognize landmarks?	☐ Yes	☐ No
Follow directions in an emergency?	☐ Yes	☐ No
Determine a new plan when you make a mistake?	☐ Yes	☐ No

Please explain any "NO" responses:

_____

_____

_____

When traveling out of your home using your most frequently used device, are you able to:

Cross a busy intersection?	☐ Yes	☐ No
Travel to your destination once exiting a vehicle?	☐ Yes	☐ No
Travel up/down hills?	☐ Yes	☐ No
Travel in areas without curb cuts?	☐ Yes	☐ No
Travel at night?	☐ Yes	☐ No
Travel in cold weather?	☐ Yes	☐ No
Travel in hot weather?	☐ Yes	☐ No
Travel in bright light conditions?	☐ Yes	☐ No
Travel when it is raining or snowing?	☐ Yes	☐ No

I certify that the information provided in this application is true and correct. I understand that falsification of information could result in a loss of ADA services.

_____ _____

Signature of Applicant (or Legal Guardian) **Date**

SOUTHERN TETON AREA RAPID TRANSIT (START)

ADA Professional Medical Verification Form

Health care providers who can complete this form (must be treating the disability for which applicant is applying for paratransit service):

Physician	Orientation & Mobility Specialist	Chiropractor
Psychiatrist/Psychologist	Respiratory Therapist	Social Worker (MSW)
Registered Nurse/PA/NP	Optometrist/Opthalmologist	Mental Health Clinician
PT / OT/ SLP		Rehabilitation Counselor

Name/Credential of Professional: _____

License Number of Professional: _____

Phone Number: _____

The Americans with Disabilities Act of 1990 (ADA) is a civil rights act that requires public transit agencies to provide Paratransit service to people whose disabilities prevent them from using accessible fixed route bus service some or all the time. The information you provide will enable us to make an appropriate determination for this applicant. All information will be kept confidential. Thank you for your assistance.

ADA paratransit service is designed for individuals who are unable to use accessible fixed route bus system due to:

a) physical, cognitive or visual impairments that require assistance from another person to travel

b) impairments related to accessible travel to/from embarking locations

Authorization for Release of Information

I hereby authorize the above-named professional to provide information about my disability and abilities to use accessible fixed route bus service for Southern Teton Area Rapid Transit (START) and/or persons assisting START in determining my eligibility for ADA service. I understand that this information will be used solely for the purpose of determining my eligibility for ADA service and that all medical information about my disability will be kept confidential.

I also understand that, at no expense to me, START Bus may require that I participate in an in-person evaluation of my travel skills and agree to such an evaluation.

_____ _____

Signature of **Applicant** or Legal Guardian Date

*****MEDICAL VERIFICATION FORMS LACKING A SIGNATURE AND LICENSE NUMBER MAY NOT BE PROCESSED*****

Please return this form to the applicant once it is completed OR scanned and emailed to info@startbus.com.

This page is to be completed by the **MEDICAL PROVIDER** regarding applicant's ability to use fixed route bus service. (please note that all START fixed route buses are accessible)

Applicant's Name: _____(d.o.b._____) Phone #_____

1. How long has this applicant been under your care? _____
2. Most recent visit date**:**_____
3. Does the applicant's disability prevent the applicant from getting to / from and riding the bus?
   ☐ Yes ☐ Sometimes ☐ No
4. If yes or sometimes, **please explain** how the applicant's disability or health related conditions prevent use of the accessible fixed route public bus system:_____
   _____
5. **Does this applicant need someone to assist him/her at all times?** ☐Yes ☐No
6. **Does the applicant have the mental capacity, visual and/or hearing ability to:**

Ask for, understand, and follow directions?	☐ Yes	☐ No
Ask for assistance from appropriate sources?	☐ Yes	☐ No
Judge traffic flow to safely cross a major street?	☐ Yes	☐ No
Safely travel through crowded/complex facilities?	☐ Yes	☐ No
Recognize a destination or landmark?	☐ Yes	☐ No
Signal a bus operator to get off at destination stop?	☐ Yes	☐ No
Filter environmental noise?	☐ Yes	☐ No

7. **Regarding vision impairments only:** ☐ N/A

Is the applicant able to locate steps or curbs?	☐ Yes	☐ No
Is the applicant impacted by bright sunlight?	☐ Yes	☐ No
Is the applicant limited by dimly lit conditions?	☐ Yes	☐ No
Is the applicant's vision impacted at night?	☐ Yes	☐ No

8. **Regarding this applicant's mobility, USING THEIR MOBILITY AID as needed, is applicant able to independently:**

Travel outdoors on their property?	☐ Yes	☐ No
Travel up to 1 block?	☐ Yes	☐ No
Travel up to 3 blocks?	☐ Yes	☐ No
Stand for up to 15 minutes with support?	☐ Yes	☐ No
Stand for up to 15 minutes without support?	☐ Yes	☐ No
Travel up or down hills?	☐ Yes	☐ No

9. These impairments are:
   ☐ Stable ☐ Progressive ☐ Degenerative ☐ Temporary, duration:_____
10. Does weather impact the applicant's ability to travel? ☐ No ☐ **Wind**
    Cold ☐ <30º ☐ <40º ☐ < 50º **Heat** ☐ >70º ☐ >80º ☐ > 90

Signature of provider_____ **Date**:_____