Access Express

Application for ADA Paratransit Service

City Utilities of Springfield, Missouri
1505 N. Boonville
Springfield, MO 65803 **Phone# (417) 831-8782**
FAX # (417) 831-8803

TRANSIT DEPARTMENT USE ONLY
______________DATE RECEIVED
______________CONTACT DATE
______ NEW APPLICATION
______ RENEWAL APPLICATION

CARD # ________________________

DATE ISSUED __________________

EXPIRATION DATE ______________

ELIGIBILITY CODE

PLEASE PRINT

Last Name__________________________ First Name_______________________ Initial_______

Address____________________________________ City___________________ Zip_________

Date of Birth (month/day/year): ______/______/______ ☐ Male ☐ Female

Daytime Phone_________________________ Evening Phone _____________________________

Please verify that you do not have access to free non-emergency medical transportation (NEMT) for scheduled medically necessary, MO HealthNet covered services by checking this box: ☐
MOHealthNet Card # _____________________________

To comply with Missouri Department of Social Services reporting requirements, please check the racial/ethnic data that applies:

☐ Alien Non-Resident ☐ Black Non-Hispanic ☐ Indian or Alaskan Native
☐ Asian or Pacific Islander ☐ Hispanic ☐ White

Emergency Contact Name _______________________________ Relationship ________________

Daytime Phone __________________________ Evening Phone ____________________________

A. MOBILITY INFORMATION

1. Which of these mobility aids or equipment do you use to help you get where you need to go? *(Please check all that apply to you.)*

☐ None	☐ Manual Wheelchair	☐ Service Animal
☐ Cane	☐ Power Wheelchair	☐ Picture Board
☐ White Cane	☐ Powered Scooter/Cart	☐ Alphabet Board
☐ Walker	☐ Portable Oxygen	
☐ Crutches	☐ Other ____________________________________	

2. Using a mobility aid or on your own, how many blocks (500 feet) can you go on level ground?
☐ None ☐ less than 2 ☐ 2 to 4 ☐ more than 4

3. If you were to ride the regular fixed route bus would you need someone with you?
☐ Always ⇨ _____ Help me get to or from the bus stop

☐ Sometimes ⇒ _____ To help me get on or off the bus
☐ No ⇒ _____ To help me when I get where I'm going

4. Have you ever had any training to learn how to access the regular fixed route bus?

☐ Yes ⇒

☐ No

The training was at: ______________________
_____I learned: (*Check all that apply to you)*
_____General bus travel
_____How to ride one or two specific routes
____ I finished the training
_____I did not complete the training

If you answered NO to the above question, would you like to have a Transit Ambassador contact you to discuss training to access the fixed route bus system?
_____ YES _____ NO

6. Do you need someone to accompany you to travel on the bus, for example, a personal care attendant? **Applicant must provide their own personal care attendant, if needed.**
_____ YES _____ NO

B. DISABILITY OR HEALTH CONDITION INFORMATION
(Please indicate all conditions which affect your ability to use the bus.)

I. The disability that prevents me from using the regular fixed route buses would place me in the following category:
_____ 1. I am unable to ride the CU bus without the assistance of someone else.
_____ 2. The bus stop is not accessible due to lack of sidewalks or curb cuts.
_____ 3. My disability prevents me from getting to and from the bus stop.
_____ 4. My disability does not prevent me from riding the CU bus.

II. Disabling Condition(s) ____
____
____
____
____
____
____
____

III. Please explain how your disability <u>prevents</u> you from using the regular fixed route bus system. Be specific. (Attach separate sheets, if necessary.)
____
____
____

____

____

____

Is your health condition or disability temporary?

_____Yes → How long do you expect it to last? __________

_____ No

_____ I don't know

C. Please mark all the categories below as they relate to your disability.

1. Do changes in weather (extreme heat, cold, wind, rain, snow, or ice) prevent you from getting around on your own?
   _____Yes → Please describe ____
   _____ No ____

2. Do you ride the regular CU fixed route bus?
   _____YES → How many days per week? ______________________________________
   _____ NO

3. Can you communicate with a bus driver yourself or with the help of an aid (such as a letter board)?
   _____YES _____ NO

4. How many blocks do you need to travel to a CU bus stop?
   _____Less than 2 _____2 to 4 _____More than 4 _____Don't know

5. How long can you wait for a bus at a bus stop? ___________ minutes

6. Can you walk up and down or climb 10-inch steps independently?
   _____ YES _____ NO

7. Are you able to independently maneuver on to or off a wheelchair ramp?
   _____YES _____ NO

8. Are you able to identify the correct bus?
   _________YES _____ NO Please explain: ____
   ____

9. Are you able to read, hear, understand and/or process information, schedules, or directions, which are needed to make necessary decisions during a trip?
   _____YES _____NO Please explain: ____
   ____

10. Are you prevented from traveling to or from a boarding location for one or more of the following reasons?
_____ Inability to negotiate hilly terrain
_____ Extreme sensitivity to climatic conditions
_____ Allergic/environmental sensitivities
_____ Hyper-fatigue, frailty
_____ Night-blindness
_____ Inability to cross busy intersections
_____ Other reasons. Please explain: ____
____

11. Are you able to give address and telephone numbers upon request?
_____ YES _____ NO. Please explain ___________________________________
____

12. Are you able to deal with unexpected situations or changes in routine? (example: bus detours)
_____ YES _____ NO. Please explain ___________________________________
____

13. Are you able to detect curbs and other drop-offs?
_____ YES _____ NO. Please explain ___________________________________
____

14. Do you have the ability to travel streets without traffic control lights?
_____ YES _____ NO. Please explain ___________________________________

15. Are you legally blind? (Legally blind is defined as: The visual acuity in your best eye with best correction is no better than 20/200, or the visual field of the best eye is constricted to less than 20 degrees.)
_____ YES _____ NO Visual Acuity: _________ Right eye ________ Left eye

16. Do you have limited vision?
_____ YES _____ NO
If yes, how does this affect your ability to ride the fixed route bus? ____________________
____

17. Are you able to handle/grasp coins (pay fare), tickets, railings, and handles?
_____ YES _____ NO. Please explain ____________________________________
____

18. Are you able to keep balance while seated on a moving vehicle?
_____ YES _____ NO. Please explain ____________________________________
____

19. How far is the closest bus stop (in city blocks) from your residence? ____________________

D. Applicant Signature

I certify that the information I gave in this application is true and correct. I understand that falsification of information may result in denial of service. I understand all information will be kept confidential, and only the information required to provide the services I requested will be disclosed to those who perform those services. I understand that City Utilities Transit may contact the health care professional who has completed the professional Verification attached to this application, to confirm this information.

Applicant's Signature____

Date____

E. Person completing form if other than applicant (please check one):

_____ I certify that the information provided in this application is true and correct based upon information given me by the applicant.

_____ I certify that the information provided in this application is true and correct based upon my own knowledge of the applicant's health condition or disability.

Exceptions or Additions:

____

____

____

Print Name ____

Relationship to Applicant ___________________________ Date _____________________

Address ____

City ______________________________ State ______________ Zip Code _____________

Daytime Phone _____________________ Signature_________________________________

*PROFESSIONAL VERIFICATION FOR ____

Patient's Name

This verification will assist in determining if applicant is unable to ride the regular fixed route bus system and therefore eligible for Access Express Paratransit (ADA Disabled) bus service for all or some trip requests based upon his/her functional ability.
Note: All City Utilities' regular fixed route buses are low-floor buses equipped with ramps to accommodate persons with wheelchairs or those who cannot climb stairs. The definition of a fixed route bus is a bus that travels on a fixed route with a set time schedule. Whereas, Access Express buses are smaller buses that are low-floor, wheelchair ramp buses that transport only those passengers that are ADA disabled and unable to ride the fixed route bus system. Access Express bus service requires reservations and is operated on a demand–responsive, origin-to-destination basis with the basic mode being curb-to-curb service.
All information will be kept confidential. Thank you for your assistance.

Capacity in which you know the applicant: ____

Is applicant able to travel on a fixed route bus that is wheelchair accessible or do they need the Access Express Bus?

____YES, Fixed Route Bus ____ NO, Access Express Bus*
*If no, what is the functional impairment that would prevent applicant from traveling on the fixed route bus?

____
____
____

Is applicant able to get to or from the bus stop with any type of mobility aid? ____ YES ____ NO*
*If no, what is the functional impairment?

____

Is this condition temporary? _____ NO _____ YES, for _________ months

_____ I have reviewed all of the information contained in this application, and hereby certify that all information is true and correct to the best of my knowledge and ability.

Please provide additional information to help us determine eligibility:

____
____
____
____
____
____

***NOTE: THIS PORTION MUST BE COMPLETED BY ONE OF THE FOLLOWING RECOGNIZED PROFESSIONALS: physician, psychologist, physical therapist, occupational therapist, nurse practitioner, physician's assistant that is employed by a medical facility.**

Print Name and Title:

Signature ______________________________ **Date** ______________________
Clinic/Agency __________________________ **Phone** _____________________
Address ______________________________ **City** ______________________
Fax Number __________________________