City of FRESNO

DEPARTMENT OF TRANSPORTATION
FRESNO AREA EXPRESS • FLEET • HANDY RIDE

2223 G Street
Fresno, California 93706
(559) 621-RIDE
www.fresno.gov

Dear Applicant:

Enclosed is a copy of the Handy Ride application you requested. Please complete all forms as stated in the cover sheet of the application. An incomplete application will be returned to the applicant, which will cause delay in processing your eligibility for the Handy Ride program.

Please check your application before submitting it to the Handy Ride office and ensure the following items have been completed.

1. Applicant's portion is complete
2. Application is signed by applicant and/or guardian
3. Physician's portion is complete and signed by a qualified **health care professional**

If you have any questions, please feel free to contact the Handy Ride office at (559) 621-5796.

Sincerely,

Handy Ride Team

Enclosure

Handy Ride Application Instructions

All applicants must submit a complete application which includes **both forms**
(1) The Certification Questionnaire
(2) The Professional Verification Form

COMPLETE The Certification Questionnaire

STEP 1

The Certification Questionnaire should be filled out by the applicant or the applicant's advocate. The form must be filled out in its entirety. It should be signed by the applicant or the applicant's guardian **and** anyone who assisted the applicant in completing the application.

STEP 2

COMPLETE The Professional Verification Forms

The Professional Verification Forms must be completed by one of the following professionals who are familiar with the applicant's condition:

- Physicians or Physician Assistants;
- Occupational Therapists;
- Psychologists or Psychiatrists;
- Physical Therapists or Chiropractors;
- Orientation and Mobility Specialist (certified by ACVREP);
- Registered Nurses (RN)

To have the *Professional Verification Forms completed*
1. Complete and sign the Authorization to Release Information.
2. Have your designated professional complete the *Professional Verification Forms (SECTION B)*.

STEP 3

SUBMIT Both the Completed *Certification Questionnaire* and *the Professional Verification Forms* together to:

Mail to:
Fresno Area Express
2223 "G" Street
Fresno, CA 93706

Fax to #
(559) 457-1589

Deliver in-person to:
Handy Ride Center
4488 N. Blackstone

Manchester Transit Center
3590 N. Blackstone

Please note that upon receipt of completed applications, it may take up to 21 calendar days for your determination of eligibility.

If FAX has not made a determination of eligibility within 21 days after the submission of an individuals completed application, the applicant will be treated as eligible and provided service until FAX makes a determination of eligibility.

STEP 4

In-Person Orientation:
After FAX Handy Ride Staff has a determination on eligibility you will then be contacted via phone and/or US mail with a date for orientation. Orientation will roughly run 30 min and you will need to provide a picture form of ID so we can create your Handy Ride card for you.

If you'll need a ride to orientation, one can be provided to you as a courtesy. Please call 559-621-5770 to schedule your ride to and from orientation. (Please reference the information sheet that was mailed out to you with your orientation appointment letter if you received one.)

Common Issues

In order to make a determination within 21 calendar days the FAX Handy Ride Center must have a complete application. There are several things which may cause an application to be incomplete. By double checking these things PRIOR to submitting your application you may avoid delays in processing.

1. **One of the forms is missing.** Your application must contain both the *Certification Questionnaire* and the *Professional Verification*. Please ensure both are complete and submitted together.

2. **One of the forms is not signed**. Both the Certification Questionnaire and the Professional Verification must be signed. If either the applicant or the professional forgets to sign the form, it may be considered incomplete.

3. **The professional credentials are missing**. Professionals must include their titles and credentials when signing the Professional Verification.

DATE RECVD:	FOR FAX STAFF ONLY:	EXPIRATION DATE:

Certification Questionnaire

Questions about this form?
Call FAX Handy Ride at (559) 621-5796, or California Relay at 711 for TTY.

Complete all parts of the form. Forms that are not fully completed will be returned, which will delay your eligibility determination.

PART 1

Applicant Data

Please print or type

Name:_____ ☐ Male ☐ Female
First Middle Initial Last

Birth Date: ___/___/_____

Street Address: _____Apt.#:_____

City: _____Zip Code:_____

***Name Cross Streets** (Ex: Shaw & Ashlan)_____

Day Telephone: (___)_____Evening Telephone: (___)_____

Mailing Address (if different from above)

Street Address: _____Apt.#:_____

City: _____Zip Code:_____

Emergency Contact Person

Name:_____Relationship:_____

Day Telephone: (___)_____Evening Telephone: (___)_____

Have you ever been enrolled in the FAX Handy Ride program? ☐ Yes ☐ No

Do you have a California ID card or California driver's license? ☐ Yes ☐ No

What is your disability?

_____

_____

_____

_____

Explain how your disability prevents you from independently using the regular city bus.

_____

_____

_____

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1. Which of the following assistive devices, if any, do you use?
(Please check all that apply.)

☐ Cane	☐ Powered Wheelchair	☐ Manual Wheelchair
☐ White Cane	☐ Powered Scooter/Cart	☐ Prosthesis
☐ Walker	☐ Communication Aid	☐ Portable Oxygen
☐ Crutches	☐ Service Animal	

☐ Other (please describe):_____

If you selected Wheelchair or Scooter, would you prefer/need to use the device while riding in FAX Handy Ride Vehicles? ☐ Yes ☐ No ☐ Sometimes

2. Are you able to travel in an automobile? ☐ Yes ☐ No

3. If you use a wheelchair or scooter:
Is it more than 33 inches wide? ☐ Yes ☐ No
Is it more than 51 inches long? ☐ Yes ☐ No
Is the combined weight of device and occupant more than 800 pounds?
☐ Yes ☐ No

4. Does your health condition/disability require you to use Handy Ride service?
☐ Permanently ☐ Temporarily _____Week(s) _____Month(s)

5. Does your health condition/disability change from day to day in ways that occasionally disrupts your ability to use regular-route city bus service?
☐ Yes ☐ No If yes, please explain:_____

PART 2 — Questions about using regular-route public transit

Complete Part 2 even if you are unable to use regular-route city bus service. This information will assist us in determining how your disability/health condition affects your ability to use regular-route city bus service.

6. Do you now independently use regular-route city buses?
☐ Yes ☐ No ☐ Sometimes ☐ Yes, but only with an attendant

If "Yes" or "Sometimes," how many times? _____per week _____per month

Which of the following best describes how you use regular-route city buses?
☐ To travel to and from one destination only
☐ To travel to and from a few destinations
☐ To travel to and from many different destinations

7. Have you ever had training to use the regular-route city buses?
☐ Yes ☐ No

8. What is the maximum distance you are able to travel without the assistance of another person?
☐ less than 1 block (<110 yards) ☐ 1-3 blocks (110-330 yards) ☐ 4-6 blocks (440-660 yards) ☐ more than 6 blocks (more than 661 yards)

9. I can wait for a regular-route city bus (check all that apply):
☐ Only if there is a bench or shelter ☐ Up to 15 min. ☐ More than 15 min.

10. Please check all the categories below as they relate to your ability to use regular-route city buses:

	I am:	Yes	No	Sometimes
A.	Able to tolerate hot or cold weather (rain, humidity)	☐	☐	☐
B.	Able to recognize destinations, bus stops, or landmarks	☐	☐	☐
C.	Able to tolerate air pollution (smog, fumes, perfume)	☐	☐	☐
D.	Free from night blindness (bright light, low light)	☐	☐	☐
E.	Able to recognize printed information	☐	☐	☐
F.	Able to hear and process spoken words or auditory information (background noise)	☐	☐	☐
G.	Able to communicate needs	☐	☐	☐
H.	Able to follow directions	☐	☐	☐
I.	Able to deal with unexpected situations or changes in routine (example: bus detours)	☐	☐	☐
J.	Able to safely and effectively travel through crowded and/or complex facilities	☐	☐	☐
K.	Able to recognize and navigate curbs, drop-offs, curb cuts and other barriers	☐	☐	☐
L.	Able to travel independently along sidewalks and other pedestrian ways	☐	☐	☐
M.	Able to cross streets independently	☐	☐	☐
N.	Able to find the correct bus stop	☐	☐	☐
O.	Able to identify the correct bus (single or multiple buses during a single trip)	☐	☐	☐
P.	Able to get on and off a bus using the lift if necessary	☐	☐	☐
Q.	Able to deposit fare into the fare box or show bus pass	☐	☐	☐
R.	Able to get to a seat/wheelchair position	☐	☐	☐
S.	Able to ride in a standing position	☐	☐	☐
T.	Familiar with what to do if I miss my bus	☐	☐	☐

If you checked “No” or “Sometimes” to any of the items in question 10, please explain:

_____

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PART 3 Applicant Signature

"The information you provide is confidential and will be treated as such. It will only be shared with agencies involved with FAX's eligibility determination process and other transit providers to facilitate travel in those areas, and will not be provided to any other person or agency, except as provided by the California Public Records Act." If you are determined ADA para-transit eligible, information about your eligibility status will be entered into a database maintained by Fresno Area Express.

I certify that all information on this application form is accurate. **I understand that misinformation or misrepresentation of facts will be cause for disqualification or rejection of my ADA eligibility.** I also understand that additional information relating to my health condition or disability may be required to determine eligibility. This information may be obtained through an in-person assessment or by requesting information from a professional who understands my health condition or disability. Additional information will be required only when the information provided on the application form does not clearly determine ADA para-transit eligibility.

*Applicant's Signature:*_____ *Date:*_____

* If the applicant is not his/her own guardian, the following information about the guardian is required:

Guardian's Name:_____
First Middle Initial Last

Day Phone: (_____)_____

*Guardian's Signature:*_____ *Date:*_____

* If someone other than the applicant or the applicant's guardian is preparing this form, please provide the following information about the preparer:

Name:_____
First Middle Initial Last

Relationship to applicant:_____

Day Phone: (_____)_____

*Preparer's Signature:*_____ *Date:*_____

Handy Ride Eligibility Application
Professional Verification

1. **Complete and sign** the *"Authorization to Release Information" below.*

2. **Have your** designated professional fill out theforms and return to you.

3. **SUBMIT Both the Completed *Certification Questionnaire* and *the Professional Verification Forms* together to:**

Mail to:
Fresno Area Express
2223 "G" Street
Fresno, CA 93706

Fax to #
(559) 457-1589

Deliver in-person to:
Handy Ride Center
4488 N. Blackstone

Manchester Transit Center
3590 N. Blackstone

SECTION A Authorization to Release Information

(when complete send to the professional you named)

Applicant's Name:_____

Date of Birth:_____/_____/_____

Applicant's Address:_____ Apt.#_____

City:_____ State:_____ Zip Code:_____

Applicant's Telephone Number: (_____)_____

I authorize the following professional to release FAX Handy Ride specific information as requested. It is my understanding that the information released will be used solely to determine my ADA paratransit eligibility. I understand that I may revoke this authorization at any time. Unless revoked, this form will allow that professional listed below to release information described for six months after the date appearing below. All healthcare information will be kept confidential.

Name of Professional: _____ Title:_____

Applicant's Signature: _____ *Date:* _____

Guardian's signature required if the applicant is not his/her own guardian,

Guardian's Signature: _____ *Date:* _____

SECTION B: Completed by Professional Health Care: Follow Instructions

Dear Health Care Professional:

The Federal Law is very specific about ADA Para-transit eligibility. You are being asked to provide information regarding this individual's disabilities. Eligibility is restricted to individuals who,

1. **As a result of their disability, cannot board, ride, or disembark from a regular fixed route bus.**
2. **Have a specific impairment related condition which prevents them from getting to or from a bus stop**.

PLEASE NOTE: This **does not** include persons who find it **difficult** or **uncomfortable** to get to and from bus stops.

In providing information you should consider only the presence of a disability or health condition and not the applicant's age or economic status.

You will be asked to include your credentials on the last page.

GENERAL INFORMATION (*Must be completed by Health Care Professional*)

Describe diagnosed disability you are currently treating this individual for and the functional limitations of this impairment:

_____
_____
_____

Date of onset ____/_____/_____ Date of last visit _____/_____/_____

How long have you worked with individual? Since _____/_____/____

Is disability temporary _____or permanent _____?
If permanent, is disability progressive? ☐ Yes ☐ No
If temporary please give best estimate of rate of recovery _____

Do temperature extremes affect the individual? (Ex. Heat index of more than 85 degrees or wind chill *less than* 32 degrees) ☐ Yes ☐ No
If yes, how so? _____

Please list current medications_____
_____
_____

Is this individual compliant with taking medications? ☐ Yes ☐ No

Can the individual currently use regular route public transportation? (all buses are equipped with wheelchair lifts)
☐ Yes ☐ No ☐ Not Sure

Does the individual's health condition/disability require they travel with someone to assist and/or supervise them? ☐ Yes ☐ No

Is the individual's judgment impaired? ☐ Yes ☐ No

Is behavioral inhibition impaired? ☐ Yes ☐ No

Can the individual walk? ☐ Yes ☐ No

Does the individual use a wheelchair or mobility aid? ☐ Yes ☐ No
Please list _____
How long has the individual been using the device(s)? _____

What is the maximum distance the individual is able to travel without the assistance of another person?
☐ less than 1block (<110 yards) ☐ 1- 3 blocks (110-330 yards) ☐ 4-6 blocks (440-660 yards) ☐ more than 6 blocks (more than 660 yards)

	Is/ Can/ Does the individual:	Yes	No	Sometimes
A	Able to live independently	☐	☐	☐
B.	Able to seek and ask directions	☐	☐	☐
C.	Able to process information	☐	☐	☐
D.	Able to follow routines (consistency)	☐	☐	☐
E.	Have basic coping skills	☐	☐	☐
F.	Have basic judgment skills	☐	☐	☐
G.	Have basic problem solving skills	☐	☐	☐
H.	Have basic orientation skills (person, place, time)	☐	☐	☐
I.	Have any concentration limitations	☐	☐	☐
J.	Have any short or long term memory limitations	☐	☐	☐
K.	Have basic orientation skill (person, place, time)	☐	☐	☐

VISUAL IMPAIRMENT

(Please complete if applicable to patient's disability)

Please provide visual acuity measurements and visual field readings for both eyes.
OS_____ OD_____

EMOTIONAL/BEHAVIOR ISSUES

Does the individual experience any of the following?
☐ Auditory hallucinations ☐ Visual hallucinations ☐ Delusions
☐ Disassociation

Does this prevent the individual from being oriented to person, place, and time?
☐ Yes ☐ No

Is the individual currently being treated for any of the following?
☐ Anxiety ☐ Depression ☐ Panic attacks ☐ Schizophrenia
☐ Other: _____

For anxiety panic attacks please indicate on average the frequency and length of panic attacks. ____ per day ____ per week ____ per month
____ per year _____ approx. duration

PLEASE PRINT SO THAT WE MAY CONTACT YOU IF NEEDED

Name of Professional: _____

Title: _____ **Professional License Number:**_____

Address: _____

City: _____ State:_____ Zip Code:_____

Telephone Number: _____ Fax:_____

Health Care Professional Signature:_____**Date**:_____

Please provide any additional information which may assist us in determining this applicant's eligibility:

_____

_____

_____

_____

_____

_____

Handy Ride staff will make the final determination on the applicant's eligibility.