Dear Applicant:

Enclosed is a copy of the Handy Ride application you requested. Please complete all forms as stated in the coversheet of the application. An incomplete application will be returned to the applicant, which will cause a 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 the applicant and/or guardian
3. The Professional Verification 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 Certification 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

**STEP 1: COMPLETE the Certification Questionnaire**

*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.

**NOTE**: Factors such as age, income, ability to drive, vehicle ownership, travel training, or access to other transportation are not used to determine eligibility or completeness of this form.

**STEP 2: COMPLETE the Professional Verification Form**

*The Professional Verification Form* must be completed by one of the following professionals who are familiar with the applicant’s condition:
- Physician or Physician Assistant
- Registered Nurse or Nurse Practitioner
- Psychologist or Psychiatrist
- Physical Therapist or Chiropractor
- Occupational Therapist
- Orientation and Mobility Specialist (certified by ACVREP)
- Licensed Clinical Social Worker

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 Form (Section B).

**STEP 3: SUBMIT FORMS**

Submit both the *Certification Questionnaire* and the *Professional Verification Form* together to one of the following:

**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 Ave.

or
Manchester Transit Center
3590 N. Blackstone Ave.
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 determined eligibility within 21 days of receipt of an individual’s complete application, the applicant will be treated as eligible and provided service until FAX makes an eligibility determination.

**STEP 4: ORIENTATION**

After an eligibility determination, FAX Handy Ride staff will contact you via phone and/or US mail regarding orientation. Orientation will run approximately 30 minutes.

During the COVID-19 pandemic, most orientations are conducted over the phone. If your orientation will be conducted in-person and 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.)

You will need to provide a picture form of ID so we can create your Handy Ride card for you. If your orientation is over the phone rather than in-person, your picture ID can be created after orientation at the Handy Ride office or Manchester Transit Center.

**Common Issues**

To make an eligibility determination within 21 calendar days the FAX Handy Ride Center must have a complete application. Several things may cause an application to be incomplete. By double-checking these things BEFORE 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 *Professional Verification Form*. Please ensure both are complete and submitted together.

2. **One of the forms is not signed.** Both the *Certification Questionnaire* and *Professional Verification Form* 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 Form*.

| Jane Doe X (Incomplete) | Jane Doe M.D. ✓ (Complete) | Jane Doe R.N. ✓ (Complete) |
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: ___________________________ Gender (optional): _____

First Middle Initial Last

Birth Date: _______ / _______ / _______

Street Address: ___________________________ Apt. #: _______

City: ___________________________ Zip Code: _______________

Community/Complex Name (e.g., Figarden Apartments): ___________________________

Primary Phone: (_____)_____________ Secondary Phone: (_____)__________

Email address (optional): ________________________________

Mailing Address (if different from above)

Street Address: ___________________________ Apt. #: _______

City: ___________________________ Zip Code: _______________

Emergency Contact Person

Name: ___________________________ Relationship: ___________________________

Primary Phone: (_____) ____________________________

Have you previously or do you currently use FAX Handy Ride? Yes ☐ No ☐

Do you have a California ID card or California driver’s license? Yes ☐ No ☐
1. Which of the following assistive devices, if any, do you use? 
(Please check all that apply.)
- [ ] Cane
- [ ] White Cane
- [ ] Powered Wheelchair
- [ ] Powered Scooter/Cart
- [ ] Manual Wheelchair
- [ ] Prosthesis
- [ ] Communication Aid
- [ ] Portable Oxygen
- [ ] Walker
- [ ] 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 a car? ☐ 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 the 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 disrupt your ability to use regular-route 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 bus service. This information will assist us in determining how your disability/health condition affects your ability to use regular-route bus service.

6. Do you now independently use regular-route FAX 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 FAX 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 regular-route buses?
   ☐ Yes ☐ No

8. What is the maximum distance you can travel without the assistance of another person (choose 1 of the 4 options below)?
   ☐ less than 1 block (110 yards or less) ☐ 1-3 blocks (110-330 yards)
   ☐ 4-6 blocks (440-660 yards) or ☐ more than 6 blocks (661 yards)

9. I can wait for a regular-route FAX bus (check all that apply):
   ☐ Only if there is a bench or shelter ☐ Up to 15 min. ☐ More than 15 min.
10. Please check one box for each category below indicating whether it is a Yes, No, or Sometimes as each relates to your ability to use regular-route FAX buses.

<table>
<thead>
<tr>
<th>Category</th>
<th>Y</th>
<th>N</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. I can tolerate hot or cold weather (rain, humidity)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. I can recognize destinations, bus stops, or landmarks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. I can tolerate air pollution (smog, fumes, perfume)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>D. I have night blindness (bright light, low light)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>E. I can recognize printed information</td>
<td></td>
<td></td>
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<tr>
<td>F. I can hear and process spoken words or auditory information</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. I can communicate my needs</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>H. I can follow directions</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>I. I can deal with unexpected situations or changes in routine (example: bus detours)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J. I can safely and effectively travel through crowded and/or complex facilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K. I can recognize and navigate curbs, drop-offs, curb cuts, and other barriers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L. I can travel independently along sidewalks and other pedestrian walkways</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M. I can cross streets independently</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N. I can find the correct bus stop</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O. I can identify the correct bus (single or multiple buses during a single trip)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P. I can get on and off a bus using the lift if necessary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q. I can deposit, swipe, or dip my fare into the farebox</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R. I can get to a seat/wheelchair position</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S. I can ride in a standing position</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T. I am familiar with what to do if I miss my bus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U. I require a Personal Care Assistant to ride with me</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If you checked “No” or “Sometimes” to any of the items in question 10, please explain:

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________
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 the FAX 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 paratransit 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 determine ADA paratransit eligibility.

**Applicant’s Signature**: __________________________________________  **Date**: __________

If the applicant has a guardian, the following information about the guardian is required:

**Guardian’s Name**: __________________________________________

  First  Middle Initial  Last

**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**: ________________________________

**Phone**: (_______) __________________________________________

**Preparer’s Signature**: __________________________________________  **Date**: __________
Handy Ride Eligibility Application
Professional Verification

2. Have your designated professional fill out the forms and return to you.
3. SUBMIT Both the Completed Certification Questionnaire and Professional Verification Form together to one of the following:

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 Ave.
        or
        Manchester Transit Center
        3590 N. Blackstone Ave.

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 to 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: ____________
Dear Healthcare Professional:

Federal Law is very specific about ADA Paratransit eligibility. You are being asked to provide information regarding this individual’s disability(ies). 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. This does not include persons who find it difficult or uncomfortable to get to and from bus stops.

In providing the requested 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 Healthcare 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 the individual? Since _____/_____/______

Is the disability temporary? _________ Or permanent? _________

If permanent, is disability progressive? ☐ Yes ☐ No

If temporary, please give your best recovery estimate ________________________________

Do temperature extremes affect the individual, e.g., heat index of more than 85 degrees (°F) or wind-chill less than 32 degrees (°F). ☐ 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 them to 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 mobility aid?  ☐ Yes  ☐ No

If yes, please list the type of device ________________________________

How long has the individual been using the device(s)? ________________________________

What is the maximum distance the individual can travel without the assistance of another person?

☐ less than 1 block (110 yards or less)  ☐ 1-3 blocks (110-330 yards)

☐ 4-6 blocks (440-660 yards)  ☐ or  ☐ more than 6 blocks (661 yards)

The individual:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Sometimes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Can live independently</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>B</td>
<td>Can seek and ask directions</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>C</td>
<td>Can process information</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>D</td>
<td>Can follow routines (consistency)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>E</td>
<td>Has basic coping skills</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>F</td>
<td>Has basic judgment skills</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>G</td>
<td>Has basic problem-solving skills</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>H</td>
<td>Has basic orientation skills (person, place, time)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I</td>
<td>Has any concentration limitations</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>J</td>
<td>Has any short- or long-term memory limitations</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

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/BEHAVIORAL 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 panic attacks please indicate on average the frequency and length of the attacks:
__________ per day ___________ per week ___________ per month
__________ per year ___________ approx. duration

PLEASE PRINT SO THAT WE MAY CONTACT YOU IF NEEDED

Healthcare Professional Name: ________________________________

Title: ____________________ Professional License #: _____________________

Address: ________________________________

City: ________________________ State: _________ Zip Code: ________________

Telephone Number: (_____) ____________ Fax: (_____) ________________

Professional’s Signature: ________________________________ Date: ________

Please provide any additional information that may assist us in determining this applicant’s eligibility.

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

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