

Joe Vargas, Director
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 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 **Healthcare 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)

DATE RECVD

IN SVC AREA

HR ID #

PRIOR EXPIRY

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: _____ 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

What is your disability?

Explain how your disability prevents you from independently using regular route FAX buses.

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

- | | | |
|---|---|--|
| <input type="checkbox"/> Cane | <input type="checkbox"/> Powered Wheelchair | <input type="checkbox"/> Manual Wheelchair |
| <input type="checkbox"/> White Cane | <input type="checkbox"/> Powered Scooter/Cart | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Communication Aid | <input type="checkbox"/> Portable Oxygen |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Service Animal | |
| <input type="checkbox"/> 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.

Y=Yes; N=No; S=Sometimes

A.	I can tolerate hot or cold weather (rain, humidity)	Y <input type="checkbox"/>	N <input type="checkbox"/>	S <input type="checkbox"/>
B.	I can recognize destinations, bus stops, or landmarks	Y <input type="checkbox"/>	N <input type="checkbox"/>	S <input type="checkbox"/>
C.	I can tolerate air pollution (smog, fumes, perfume)	Y <input type="checkbox"/>	N <input type="checkbox"/>	S <input type="checkbox"/>
D.	I have night blindness (bright light, low light)	Y <input type="checkbox"/>	N <input type="checkbox"/>	S <input type="checkbox"/>
E.	I can recognize printed information	Y <input type="checkbox"/>	N <input type="checkbox"/>	S <input type="checkbox"/>
F.	I can hear and process spoken words or auditory information (background noise)	Y <input type="checkbox"/>	N <input type="checkbox"/>	S <input type="checkbox"/>
G.	I can communicate my needs	Y <input type="checkbox"/>	N <input type="checkbox"/>	S <input type="checkbox"/>
H.	I can follow directions	Y <input type="checkbox"/>	N <input type="checkbox"/>	S <input type="checkbox"/>
I.	I can deal with unexpected situations or changes in routine (example: bus detours)	Y <input type="checkbox"/>	N <input type="checkbox"/>	S <input type="checkbox"/>
J.	I can safely and effectively travel through crowded and/or complex facilities	Y <input type="checkbox"/>	N <input type="checkbox"/>	S <input type="checkbox"/>
K.	I can recognize and navigate curbs, drop-offs, curb cuts, and other barriers	Y <input type="checkbox"/>	N <input type="checkbox"/>	S <input type="checkbox"/>
L.	I can travel independently along sidewalks and other pedestrian walkways	Y <input type="checkbox"/>	N <input type="checkbox"/>	S <input type="checkbox"/>
M.	I can cross streets independently	Y <input type="checkbox"/>	N <input type="checkbox"/>	S <input type="checkbox"/>
N.	I can find the correct bus stop	Y <input type="checkbox"/>	N <input type="checkbox"/>	S <input type="checkbox"/>
O.	I can identify the correct bus (single or multiple buses during a single trip)	Y <input type="checkbox"/>	N <input type="checkbox"/>	S <input type="checkbox"/>
P.	I can get on and off a bus using the lift if necessary	Y <input type="checkbox"/>	N <input type="checkbox"/>	S <input type="checkbox"/>
Q.	I can deposit, swipe, or dip my fare into the farebox	Y <input type="checkbox"/>	N <input type="checkbox"/>	S <input type="checkbox"/>
R.	I can get to a seat/wheelchair position	Y <input type="checkbox"/>	N <input type="checkbox"/>	S <input type="checkbox"/>
S.	I can ride in a standing position	Y <input type="checkbox"/>	N <input type="checkbox"/>	S <input type="checkbox"/>
T.	I am familiar with what to do if I miss my bus	Y <input type="checkbox"/>	N <input type="checkbox"/>	S <input type="checkbox"/>
U.	I require a Personal Care Assistant to ride with me	Y <input type="checkbox"/>	N <input type="checkbox"/>	S <input type="checkbox"/>

Handy Ride Eligibility Application Professional Verification

1. Complete and sign the “Authorization to Release Information” below.
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:** _____



SECTION B: Completed by Healthcare Professional

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:	Yes	No	Sometimes
A. Can live independently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Can seek and ask directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Can process information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Can follow routines (consistency)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Has basic coping skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Has basic judgment skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Has basic problem-solving skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Has basic orientation skills (person, place, time)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Has any concentration limitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Has any short- or long-term memory limitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

<p>Healthcare Professional Name: _____</p> <p>Title: _____ Professional License #: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip Code: _____</p> <p>Telephone Number: (____) _____ Fax: (____) _____</p> <p>Professional's Signature: _____ Date: _____</p>
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<p>Please provide any additional information that may assist us in determining this applicant's eligibility.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

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