City of FRESNO

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

CITY OF FRESNO DEPARTMENT OF TRANSPORTATION

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. The applicant's portion is complete.
2. The 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

FAX FRESNO AREA EXPRESS

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

Email to:
HandyRideApps@fresno.gov

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 for approximately 30 minutes.

Orientations can be completed in person or over the phone. We can determine the best option for you when we call you. 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.

If your orientation is over the phone, we will mail your Handy Ride ID with no picture. A picture ID can be created after orientation at the Handy Ride office or Manchester Transit Center.

For in-person orientation, you will need to provide a picture form of ID so we can create your Handy Ride picture ID for you.

Common Issues

To make an eligibility determination within 21 calendar days the FAX Handy Ride office 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 the *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/or credentials when signing the *Professional Verification Form*.

RESERVED FOR FAX STAFF ONLY				
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., Fig Garden Apartments)*: _____

Primary Phone: (_____)_____

Secondary Phone: (_____)_____

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.)

☐ 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 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 FAX Service

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

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

PART 3 – Applicant Signatures

The information you provide is confidential and will be treated as such. The use of this information will be limited to Fresno Area Express (FAX) staff or FAX authorized agents involved with: the eligibility determination process; the provision of Handy Ride service; outreach or customer satisfaction (contact information only); satisfying current or future legislative/regulatory/court issued mandates; California Public Records Act requirements; or other transit providers to enable eligible travel. If you are determined eligible, information about your eligibility status will be entered into a database maintained by FAX.

I certify that all information on this application form is correct. **I understand that misinformation or misrepresentation of facts will be cause for disqualification or rejection of my application.** 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 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

1. **Complete and sign** the *"Authorization to Release Information"* below.
2. **Have your** designated professional fill out the forms and return them 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

Email to:
HandyRideApps@fresno.gov

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 that 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 the 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	☐	☐	☐
B.	Can seek and ask for directions	☐	☐	☐
C.	Can process information	☐	☐	☐
D.	Can follow routines (consistency)	☐	☐	☐
E.	Has basic coping skills	☐	☐	☐
F.	Has basic judgment skills	☐	☐	☐
G.	Has basic problem-solving skills	☐	☐	☐
H.	Has basic orientation skills (person, place, time)	☐	☐	☐
I.	Has any concentration limitations	☐	☐	☐
J.	Has any short- or long-term memory limitations	☐	☐	☐

VISUAL IMPAIRMENT

(Please complete <u>if applicable</u> to the 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 _____ approximate 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.