

DURANGO TRANSIT
250 W 8th St
DURANGO CO 81301-5109

FOR INFORMATION CALL 247-3577
(VOICE/TDD)
FAX 1-888-317-8835

Dear Opportunity Bus Patron:

Thank you for your interest in our paratransit bus service. In accordance with the Americans With Disabilities Act (ADA) of 1990, Durango Transit's paratransit service (the Opportunity Bus) provides service to persons qualified under the ADA or persons sixty (60) years of age or older. Please help us determine your eligibility by completing the enclosed form and returning it to Durango Transit, 250 W 8th St, Durango, CO 81301

PLEASE READ THE FOLLOWING GUIDELINES:

1. If you are already using the Opportunity Bus and are currently ADA eligible, you will need to complete the enclosed questionnaire to renew your ADA eligibility.
2. If you are already ADA eligible and currently hold an active eligibility ID card from another transportation agency, you may use it for up to three weeks on the Opportunity Bus system. If you will be using the Opportunity Bus for more than three weeks, you will need to complete the enclosed questionnaire as explained below.
3. If you are 60 years of age or older and/or you need to be certified as ADA eligible, you will need to complete the enclosed questionnaire.
4. Completion of the PARATRANSIT ELIGIBILITY QUESTIONNAIRE:
 - a. All applicants need to complete PART A of the questionnaire.
 - b. The completed questionnaire may be either mailed to Durango Transit or given to a Durango Transit operator. Please use the enclosed self-addressed envelope.
 - c. If you answer **NO** to questions 2 and 3 in PART A, it is not necessary to complete PART B. Simply sign the form and return it to Durango Transit.
 - d. If you answer **YES** to question 2 or 3 in PART A of the questionnaire and you have a disability which is self-evident (for example, you require a wheelchair), you may complete PART B of the questionnaire yourself (or have someone complete it for you) and return it to Durango Transit.
 - e. If you answer **YES** to question 2 or 3 in PART A of the questionnaire and you have a disability which is NOT self-evident, you will need to have a health care professional complete and sign PART B. Please give the enclosed letter (addressed "DEAR HEALTH CARE PROFESSIONAL") to the professional who will be completing your questionnaire. (*You may simply drop this paperwork off at his/her office.*) Once completed and signed by your health care professional, the questionnaire needs to be returned to Durango Transit.
5. Durango Transit will contact you in writing with your eligibility determination within 21 days of receiving your completed questionnaire. Depending on the nature of your disability, you will receive full, conditional, or temporary eligibility status.

Thank you for taking the time to read these instructions. Please feel free to contact us at the above address or phone number if you have any questions about this.

**Durango Transit Opportunity Bus
PARATRANSIT ELIGIBILITY QUESTIONNAIRE**

The information obtained in this questionnaire will be used only by Durango Transit for the provision of transportation services. Please complete and return this form to: Durango Transit 250 W 8th St. Durango, CO 81301, 970-247-3577, www.durangogov.org (fax) 1-888-317-8835

PART A

CLIENT INFORMATION

NAME: _____

ADDRESS:(Physical) _____

CITY & STATE _____ ZIP CODE _____

PHONE NUMBER (HOME) _____ (WORK) _____

DATE OF BIRTH: Month _____ Day _____ Year _____ (Please include year)

In case of emergency, please contact:
Name & Relationship _____ Day Phone # _____

(Please note - spouse must complete separate application.)

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Are you 60 years of age or older? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have a disability which <u>prevents</u> you from <u>reaching</u> a fixed route transit stop? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have a disability which <u>prevents</u> you from <u>using</u> the Durango Transit's fixed route transit services? | <input type="checkbox"/> | <input type="checkbox"/> |

- If you answered NO to questions 2 and 3 above, it is not necessary to complete PART B. You may simply sign here and return this to Durango Transit. Other applicants sign below and continue to PART B.

Signed _____

- If you answered **YES** to questions 2 or 3 above, you will need to complete the remainder of this form or have someone complete it for you.
- ***If you have a disability that is not self-evident, PART B below must be completed by a health care professional. If disability is self-evident applicant must complete PART B.***

PART B

ADA ELIGIBILITY INFORMATION

Professional's Name and Title: _____

Office Address: _____

Office Telephone Number: _____

Dear Health Care Professional: Please complete the following information. If you believe that your client's ability to perform some of the following is based only under certain conditions, please explain. If you have other comments relevant to their condition and/or eligibility, please make note by the appropriate question. Your cooperation is appreciated.

Can you (your client):

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Step up 17 inches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Board/disembark a vehicle unassisted? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Conduct the fare transaction? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Independently identify or communicate to the driver the desired destination? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Transfer between vehicles, as necessary? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Wait outside for 10 minutes without support? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Walk: | | |
| a. 4 blocks to a transit stop? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. 2 blocks to a transit stop? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. 200' to a transit stop? | <input type="checkbox"/> | <input type="checkbox"/> |

Do you (Does your client):

YES NO

8. Have a visual disability that prevents use of fixed route transit services?

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Explain _____

9. Have a hearing disability that prevents use of fixed route transit services?

--	--

Explain _____

10. Have a cognitive disability?

--	--

If yes, can they: If no, go to #11

a. Give addresses and phone #'s on request?

--	--

b. Recognize a destination or landmark?

--	--

c. Cope with unexpected situations or changes in routing?

--	--

d. Ask for, understand, and follow directions?

--	--

11. Have a temporary condition which prevents use of the fixed route services?

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If yes, for how long (until what date)? _____

12. Use any equipment or aids for mobility or communication?

--	--

What type(s)? _____

13. Carry an oxygen tank?

--	--

14. Need help getting from the door to the curb?

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15. Require the assistance of a personal care attendant and/or guide animal?

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16. What is the medical diagnosis or condition causing your (client's) disability?

17. If eligibility is conditional, please explain in detail: _____

If there is another contact person working with this client, please indicate his/her name, the name of the agency, and the office phone #: _____

Name and Signature of person(s) completing this form		
Health Care Professional:	Client/Other:	(Relationship to client ____)
_____	_____	_____
Print Name	Print Name	
_____	_____	
Signature	Signature	
Date _____	Date _____	Day Phone _____

<u>DURANGO TRANSIT USE ONLY</u>						
Date rec'd _____	Eligibility:	ADA	Non-ADA	Cond.	Temp.	None
Resp. mail'd _____						
Date _____	Note:	_____				
Date _____	Note:	_____				
Date _____	Comment:	_____				
Date _____	Transit Manager Signature:	_____				