PARATRANSIT

Eligibility Application

For questions or help, call **360-733-1144**.

Return completed application to:

Fax: (360) 527-4867
Attn: Eligibility Specialist

or

Eligibility Specialist
Whatcom Transportation Authority (WTA)
4011 Bakerview Spur
Bellingham, WA 98226

Applicant Information

Last Name _____

First Name _____ Middle Initial _____

Date of Birth ____ / ____ / _____ Phone Number _____

Primary Language _____ Male ☐ Female ☐

Primary Pickup Location *(your home or place where you will start most trips)*

Address _____ Apt./Unit _____

City _____ State _____ Zip Code _____

Mailing Address *(if different than above)*

Address _____ Apt./Unit _____

City _____ State _____ Zip Code _____

Emergency Contact

Name _____ Phone Number _____

Relationship to Applicant _____

Answer all of the questions below. To avoid delays, provide complete and detailed answers. A signature is required at the end of this form (pg. 7). Your eligibility for paratransit service will be based on whether your disability or condition prevents you from using fixed route bus service as described in the Americans with Disabilities Act (ADA).

Disability or Condition

What is the disability or condition that prevents you from using fixed route bus service?

Is your disability or condition temporary?

No ☐ Yes ☐ If Yes, how long will it last? _____

Does your disability or condition vary from day to day?

No ☐ Yes ☐ If Yes, please explain?

Does your disability or condition prevent or limit your ability to travel by yourself?

No ☐ Yes ☐ If Yes, please explain:

Your Pickup Location

It may be hard for our minibus to reach your pickup location if there are steep driveways, narrow roads, or no place to turnaround. This will not affect your eligibility, but we need to know if access could be a problem.

No ☐ Yes ☐ If Yes, please explain:

Ability Checklist

Please check the box that applies:

No	Yes	Sometimes	
☐	☐	☐	I walk slowly.
☐	☐	☐	I can grip railings and handles.
☐	☐	☐	I can handle coins and tickets.
☐	☐	☐	I know and can communicate my address and phone number.
☐	☐	☐	I can recognize locations and landmarks.
☐	☐	☐	I can deal with unexpected situations.
☐	☐	☐	I can ask for, understand, and follow directions.
☐	☐	☐	I can cross busy streets.
☐	☐	☐	I can travel where the ground is not level or is rough.
☐	☐	☐	I can travel when there is snow and ice.
☐	☐	☐	I can travel in very hot weather.
☐	☐	☐	I can travel in darkness or low light.
☐	☐	☐	I can travel in bright light.
☐	☐	☐	I can travel if someone has shown me the way.
☐	☐	☐	I can travel from my front door to the curb.

Additional Information

Please list anything else you want us to know about your disability or condition. Also list any concerns you have about riding the bus.

Condition Checklist

Please check all that apply to you:

- ☐ Amputation
- ☐ Autism
- ☐ Balance Problems
- ☐ Blind or Low Vision
- ☐ Brain Injury
- ☐ Breathing Condition
- ☐ Cognitive Disability
- ☐ Confusion
- ☐ Deaf or Hard of Hearing
- ☐ Dialysis Required
- ☐ Frail
- ☐ Memory Loss
- ☐ Non Verbal
- ☐ Obesity
- ☐ Pain
- ☐ Panic
- ☐ Paralysis
- ☐ Psychosis
- ☐ Seizures
- ☐ Significant Limitation of Activity

Mobility Aids

When you travel outside your home what mobility aids do you use? **Check all that apply:**

- ☐ None
- ☐ White cane
- ☐ Support/quad cane
- ☐ Walker
- ☐ Portable Oxygen
- ☐ Other *(please specify)* _____
- ☐ Powered wheelchair
- ☐ Manual wheelchair
- ☐ Powered scooter
- ☐ Personal Care Attendant (PCA)
- ☐ Service animal

Wheelchair or Scooter Information

If you use a wheelchair or scooter answer the following questions:

What is the size of your wheelchair or scooter?

Width: _____ inches *(side to side)*

Length: _____ inches *(front to back)*

Is the combined weight of you and your wheelchair or scooter more than 600 pounds? No ☐ Yes ☐

If Yes, how much is your combined weight? _____ lbs Don't know ☐

Travel Abilities

How far can you travel by yourself (using your mobility aids)? _____

If you were waiting for a ride could you:

Stand for 10 minutes? No ☐ Yes ☐

Sit for 10 minutes? No ☐ Yes ☐

Do you currently use Fixed Route bus service? No ☐ Yes ☐

If No, why have you not used Fixed Route bus service? **Check all that apply:**

- ☐ I have never tried
- ☐ I need someone to show me how
- ☐ I have difficulty getting on or off the bus
- ☐ I have difficulty recognizing bus stops
- ☐ I have difficulty traveling to and from the bus stop
- ☐ Other _____ *(please specify)*

Professional Verification and Release of Information

Please provide contact information for at least one professional care provider who can provide us with relevant details about your disability or condition.

Name _____ Profession _____

Address _____ Suite _____

City _____ State _____ Zip Code _____

Phone Number _____ Fax Number _____

Name _____ Profession _____

Address _____ Suite _____

City _____ State _____ Zip Code _____

Phone Number _____ Fax Number _____

Medical Information Release

I_____authorize the above provider(s), and their
(applicant's name)

office staff, to provide information to WTA about my functional abilities and medical diagnoses in order to verify my eligibility for paratransit service. I understand this release expires one year from today. I also may revoke this release any time by notifying WTA in writing.

_____ _____
Applicant Signature Date

_____ _____ _____
Person Assisting with Application Signature *(if applicable)* Printed Name Date

Relationship to Applicant _____ Phone Number _____

Declaration

I understand that eligibility for paratransit service is governed by the Americans with Disabilities Act (ADA) and is for people whose disability or condition prevents them from using fixed route bus service.

I understand that giving false information is against the law (RCW 9A.72.085 and RCW 40.16.030) and could result in losing access to paratransit services.

I understand that WTA may ask me to participate in a capability assessment or ask for a professional verification of my capabilities.

I understand that WTA will not use the information I provide for any purpose other than determining my eligibility or providing me with service and will keep it confidential and will not share it without my written permission.

_____ _____

Applicant Signature Date

_____ _____ _____

Legal Guardian or Power of Attorney Signature *(if applicable)* Printed Name Date

- *Please attach proof of legal guardianship or power of attorney.*

_____ _____ _____

Person Assisting with Application Signature *(if applicable)* Printed Name Date

Relationship to Applicant _____ Phone Number _____