

**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 949 E. 2nd Ave Durango, CO 81301, 970-247-3577, www.durangogov.org

PART A

CLIENT INFORMATION

NAME: _____

ADDRESS: _____

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?

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Explain _____

10. Have a cognitive disability?

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

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

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b. Recognize a destination or landmark?

--	--

c. Cope with unexpected situations or changes in routing?

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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 _____	ADA Card Issued? _____	Date Issued _____	Exp. _____			
Date _____	Note: _____					
Date _____	Note: _____					
Date _____	Comment: _____					
Date _____	Transit Manager Signature: _____					