The City of Elk Grove’s ADA Paratransit e-van is a “Safety Net” for people with physical, cognitive or visual disabilities that are functionally unable to independently use the fixed-route service either all of the time, temporarily, or only under certain circumstances.

Eligibility Certification is conducted at:
City of Elk Grove, Transit Services
8401 Laguna Palms Way
Elk Grove, CA 95758
PHONE: 916-627-3555/FAX: 916-627-4804

Steps in the Eligibility Process

1. Complete the Paratransit Application that follows this page.

2. Mail or fax your signed and completed application and Professional Verification statement from your healthcare provider when required to: City of Elk Grove Transit Services, Attn: ADA Certification, 8401 Laguna Palms Way, Elk Grove, CA 95758 or Fax to 916-627-4804, Attn: Transit Services. An incomplete application will be returned and will delay processing.

3. You may be asked to attend an in-person interview. Your eligibility will be determined within 21 days from the date you complete your telephone and/or in-person interview and functional assessment. You will be notified by letter as to your eligibility status.

4. If you do not receive written notice of the City of Elk Grove’s decision within 21 days, you may request paratransit services until a decision has been made by calling (916) 627-3555
Please complete all sections of this form. All information will remain confidential.

PART A - APPLICANT INFORMATION (PLEASE PRINT)

☐ New Application or ☐ Recertification

First Name__________________________________________ Middle Initial__________

Last Name__________________________________________

Street Address__________________________________________ Apt#__________

Apt. Complex/Care Facility__________________________________________
(if applicable)

Mailing Address__________________________________________
(if different from street address)

City_________ State_______ Zip_________ County_________

Phone (daytime) ____________________________________ (evening) ________________

Cellular #__________________________ TTY for hearing impaired________________________
(if applicable)

Date of Birth______/______/______ Sex: ☐ Male ☐ Female

Month Day Year

Please send me written information in an alternate format.
☐ Large Print ☐ Audio Tape ☐ Braille ☐ CD ☐ Other:________________________

Please provide the name of a LOCAL relative/friend in case of an emergency:

Name__________________________________________ Relationship________________________

Phone (daytime) ________________________ (evening) ________________________
PART B - FUNCTIONAL INFORMATION

How do you travel now? Please check all that apply to you.

☐ walk  ☐ drive a car  ☐ ride in someone’s car  ☐ taxi  ☐ bicycle

☐ e-tran  ☐ e-van  ☐ RT bus/light rail train  ☐ Other:______________

What types of disabilities cause you to be unable to use the accessible fixed-route buses and light rail trains?

☐ physical disability  ☐ visual impairment/blindness  ☐ developmental disability

☐ mental illness  ☐ recent surgery  ☐ other______________

Diagnosed when:______________  Stable or Progressive:______________

Is your disability temporary?

☐ Yes, I expect it to last_______months.

☐ No, it is permanent.

☐ I don’t know.

Do you need to travel with someone who will assist you with your trip?

☐ No  ☐ Yes  ☐ Sometimes

Please explain when you need the help of another person to make your trip:

___________________________________________________________________

___________________________________________________________________

Can you maintain balance while seated on a moving vehicle?

☐ Yes  ☐ No

How far can you go on level ground (with your mobility aid, if you use any)?

☐ Up to 1 block  ☐ 2 blocks  ☐ 3 blocks  ☐ 4 or more blocks

Are you able to climb three (3) 12” steps using a handrail?

☐ Yes  ☐ No  ☐ Only with great difficulty
PART C - CURRENT USE OF ACCESSIBLE FIXED-ROUTE BUSES & LIGHT RAIL

Have you ever used the fixed route bus system (Examples- e-tran or Sacramento Regional Transit)?

☐ Yes  □ No  If yes, how often? ___

Yes, I used to but stopped because___

No, I have never tried because__________________

PART D - MOBILITY AID AND/OR EQUIPMENT INFORMATION

Which of these mobility aids do you use? Please check all that apply to you.

☐ white cane  ☐ powered wheelchair*  ☐ walker
☐ support cane  ☐ 3-wheel scooter/cart*  ☐ walker with seat
☐ crutches  ☐ manual wheelchair*  ☐ portable oxygen
☐ leg brace  ☐ power assist wheelchair  ☐ prosthesis
☐ service animal  ☐ communication board  ☐ no mobility aid
☐ other (please specify)___________________________

* “Wheelchair” means a three or more wheeled mobility device.

Is your mobility device oversized?

☐ Yes  □ No  □ Does not apply

If yes, please explain___________________________

Does your mobility device weigh less than 800 pounds when occupied?

☐ Yes  □ No

Do you know how much you and your wheelchair weigh together?

☐ Yes  □ No

If yes, please provide the total weight:___________________lbs

Can you transfer from your mobility device into a passenger seat?

☐ Yes  □ No
PART E - APPLICANT CONDITION DETAIL

Please explain what and how your disability or health-related condition prevents you from using public transit – please be specific. Do not use acronyms.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

PART F - CERTIFICATION OF APPLICANT

I understand the information I provided on this application is true and correct to the best of my knowledge. The purpose of this application is to determine if I am eligible to use e-van Paratransit services, or if at times I can ride the fixed-route buses and light rail trains. I understand that falsification of information could result in a loss of e-van Paratransit services as well as a penalty under the law.

I also understand that, at no expense to me the City of Elk Grove may require that I participate in an in-person functional evaluation of my travel skills and agree to such a functional evaluation if one is necessary.

I agree to notify the City of Elk Grove if my condition changes, if my mobility device has been replaced, if I have a new mobility device, or if I no longer need to use e-van Paratransit service.

________________________________________________________________________

(Signature of Applicant or Guardian if Applicable)

Date________________

Person Completing Application If Not the Applicant:

Printed Name________________________ Relationship to Applicant________________________

Signature______________________________________________ Date________________________

Daytime Phone #________________________ Evening Phone #________________________
To The Applicant - Please have this page completed before mailing your application to the City. Any one of the professionals listed below may sign the application. If the signature page is not signed by one of these professionals, the application will be returned to you, and completion of your ADA eligibility evaluation will be delayed.

To the Professional - Please check your professional title:

- physician
- physician’s assistant
- registered nurse/nurse practitioner
- psychiatrist
- psychologist
- case/resource manager
- chiropractor
- physical therapist
- occupational therapist
- special education teacher
- certified speech therapist
- vocational rehabilitation counselor
- certified orientation & mobility specialist

The ADA regulations state that persons are eligible for e-van paratransit service if, because of a disability or medical condition, they are physically or cognitively unable to (not discomforted by or find difficult) independently using lift-equipped public transit service. Depending on their disability, people can be eligible sometimes, or all of the time. ADA e-van paratransit eligibility is not based on the person’s lack of knowledge of bus service, distance from bus service, ability to drive, discomfort with riding the bus, language ability, or age. The information you provide will help determine under what circumstances this applicant’s disability causes him/her to be unable to travel using lift-equipped buses or light rail trains and therefore would need to travel using a shared-ride e-van paratransit service.

NAME OF APPLICANT:

Please describe the medical diagnosis, physical or cognitive disability which causes the applicant to be unable to independently use a lift-equipped bus or light rail train some, or all of the time:

________________________________________________________________________
________________________________________________________________________

Is this condition temporary? □ No □ Yes for: □ 4 mos □ 6 mos □ 9 mos □ 12 mos

This person □ is □ is not able to self-supervise daily activities

Last date of face-to-face contact with this applicant was ______ / ______ / ______

I certify under penalty of perjury under the laws of the State of California that the information contained in this application is true and correct.

Signature___________________________________________ Date______ / ____ / ______

Printed Name_________________________________________ Phone____________________

Clinic/Agency________________________________________ Address_________________

City________________________ State________ ZIP_________

If Applicable: Professional License/Registration/Certification#________________ State____