

ISLAND PARATRANSIT CERTIFICATION OF ELIGIBILITY

The information obtained in this certification process will only be used by Island Transit for the provision of transportation services. Information will only be shared with other transit providers to facilitate travel in those areas. The information will not be provided to any other person or agency.

PLEASE PRINT (Please Do Not FAX)

Your Name: _____

You live on: Whidbey Island Camano Island

Your Address is located in the: North Central South area of the Island

Address: _____ City: _____ State: _____

Post Office Box: _____ City: _____ State: _____

Name of Complex: _____ Special notes: _____

Zip: _____ Phone: Home: () _____ Work: () _____

Your Date of Birth: _____ Male Female

Name, Address and Phone of a person to contact in case of Emergency:

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: () _____ Work: () _____ Cell: () _____

For Office Use Only Do Not Mark Below For Office Use Only Do Not Mark Below

Date Received: _____	Date Approved: _____	Application Number: _____
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Eligibility Code:

<input type="checkbox"/> Can never take fixed route	<u>W-Wheelchair</u>	<input type="checkbox"/> Distance to/from bus
<input type="checkbox"/> Can ride fixed route if taken there	<input type="checkbox"/> Manual	<input type="checkbox"/> Transfer to fixed route
<input type="checkbox"/> Can ride Route Deviation	<input type="checkbox"/> Power	<input type="checkbox"/> Hours of darkness

PRIMARY MOBILITY AID:

<input type="checkbox"/> AB-Alphabet Board	<input type="checkbox"/> Scooter	SPECIAL CONDITIONS
<input type="checkbox"/> CA-Cane	<input type="checkbox"/> Unusual	
<input type="checkbox"/> CR-Crutches		
<input type="checkbox"/> OX-Oxygen		
<input type="checkbox"/> PB-Picture Board		
<input type="checkbox"/> PR-Prosthesis		
<input type="checkbox"/> LR-Lift Required		
<input type="checkbox"/> SA-Service Animal		
<input type="checkbox"/> WA-Walker		
<input type="checkbox"/> PCA <input type="checkbox"/> Yes <input type="checkbox"/> No		

SERVICE LEVEL OF ASSISTANCE

<input type="checkbox"/> Slope	<input type="checkbox"/> BI-Behavioral issues
<input type="checkbox"/> Terrain	<input type="checkbox"/> DB-Deaf & blind
<input type="checkbox"/> Weather/Adverse Temp	<input type="checkbox"/> HI-Hearing impaired
<input type="checkbox"/> Architectural	<input type="checkbox"/> NV-Non verbal
<input type="checkbox"/> Distance To/From	<input type="checkbox"/> VI-Vision impaired
	<input type="checkbox"/> CTC-Curb to curb
	<input type="checkbox"/> VAE-Visually assured
	<input type="checkbox"/> DNLA-Do not leave alone

A. REGULAR FIXED BUS ROUTE SERVICE

Island Transit provides regularly scheduled fixed route bus service throughout the day, Monday through Saturday. Our regularly scheduled fixed route bus service provides more independence and mobility choices for your daily planning and activities.

TRAVEL TRAINING PROGRAM

Would you like assistance learning how to use our regularly scheduled service which will help you become more comfortable? Would you like to be able to ride the bus any time without making reservations? Want to know more? Give us a call! **360-678-7771**

1. Have you previously used our Fixed - Route service?
 YES NO
2. How far do you live from the Fixed - Route, regular service?
 Less than 2 blocks 2-4 blocks More than 4 blocks Don't know
3. Are you able to get to and from an Island Transit bus stop?
 YES NO

B. HELP US TO GET TO KNOW YOU BETTER

1. Please tell us about your disability or health condition:

2. Is your health condition or disability temporary?
 Yes → I expect it to last _____Months.
 No, it's permanent.
 I don't know.

3. Can you climb up and down three, 12 inch steps to get on and off the bus?
 Yes No If **no** is lift required? Yes No

4. Are there any other effects of your disability of which Island Transit needs to be aware of?

5. What is the maximum period you can wait without support? _____ Minutes? _____

6. Is the time periods affected by extremes of hot or cold? Yes No

7. If yes, please describe below:

8. Can you walk 200 feet without assistance of another person? Yes No Sometimes.

9. Can you walk ¼ mile without assistance of another person? Yes No Sometimes.

10. Can you walk ¾ mile without assistance of another person? Yes No Sometimes.

*The following information will be used to insure that the **appropriate vehicle** is utilized to provide your transportation needs and an accurate analysis of your trip requests can be made by Paratransit.*

9. Do you use any of the following aids for mobility? (Check all that apply)

- | | | | |
|---|------------------------------|-----------------------------|--------------------------|
| Manual Wheelchair | <input type="checkbox"/> | Crutches | <input type="checkbox"/> |
| Electric Wheelchair | <input type="checkbox"/> | Cane | <input type="checkbox"/> |
| Powered Scooter | <input type="checkbox"/> | Service Animal | <input type="checkbox"/> |
| Can you transfer from your <u>Scooter</u> to a seat in the bus? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Personal Care Attendant (PCA) | <input type="checkbox"/> | Any other Aid | <input type="checkbox"/> |

If you use a Wheelchair / Scooter, what is the Length _____ inches, Width _____ inches.
What is the make of your scooter? _____

Does the total weight of your Wheelchair / Scooter and you exceed 600 pounds? Yes No

Are you able to Operate your wheelchair/scooter on your own? Yes No

If not, we require someone goes with you to help you to and from your destination (a PCA).

I hereby certify that the information given above is correct.

Signature : _____ Date: _____

If this application has been completed by someone other than the person requesting certification that individual must complete the following information:

Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: Home: (_____) _____ Work: (_____) _____

Permission for Release of Information Form

(This would give us permission to ask your healthcare professional for information of your disability.)

In order to allow Island Paratransit to evaluate your request, it may be necessary to contact a physician or other professional to confirm the information you have provided. Please complete the following information:

Please identify the professional best able to verify your functional ability to use transit services. For example, if you use a mobility aid or are physically unable to get to or from a bus stop or on a bus, identify, if possible a rehabilitation counselor, independent living counselor, occupational therapist, or other such professional knowledgeable of your functional abilities. If you have a cardiac condition, visual impairment, or temperature sensitivity, identify a physician or health care professional with the appropriate specialty to provide information about your condition. If you have a cognitive or developmental disability, identify, if possible, an independent living counselor or other social service professional familiar with your capabilities.

Please Check one of the following:

- | | | | |
|------------------------------|--------------------------|-----------------------------|--------------------------|
| Rehabilitation Counselor | <input type="checkbox"/> | Social Service Professional | <input type="checkbox"/> |
| Independent Living Counselor | <input type="checkbox"/> | Physician | <input type="checkbox"/> |
| Occupational Therapist | <input type="checkbox"/> | Health Care Professional | <input type="checkbox"/> |

I HAVE RECEIVED "ISLAND TRANSIT'S NOTICE OF PRIVACY PRACTICES".

SIGNATURE: _____ **DATE:** _____

The above Professional is familiar with my disability and is authorized to provide information to Island Transit as required to complete this certification.

Please print or type

Professional's Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone : (_____)
Your Birth Date: _____
Your Signature : _____ Date : _____

Please send completed eligibility forms to:

**Island Paratransit
P.O. Box 1735
Coupeville, WA 98239**