VVTA RFP 2025-04 ADA COMPLEMENTARY PARATRANSIT ELIGIBILITY CERTIFICATION SERVICES ADDENDUM NO. 1

Thursday, May 1, 2025

The following questions were posed prior to the deadline on Friday, April 25, 2025, as well as the answers from VVTA Staff:

Q1: "Instructions to Proposers: Page 6 (SIC): Section B: Purpose: *"Applicant's functional capabilities may vary with circumstances such as weather conditions, terrain, and travel training availability."* Does the ADA Certification Contractor take an active role in recommending travel training for applicants that may benefit from the service."

A1: This is a function that is provided by the awarded ADA Cert contractor.

Q2: "Instructions to Proposers: Page 7: Section I: Format of Proposals, #1e: Item II: *"Education, qualifications, and specific experience in performing the work that is being solicited in this RFP, especially related to the construction of a fueling station – hydrogen preferred."* Please confirm if the description in red is a requirement of this RFP."

A2: This was a typo and should be as related to the subject of this RFP.

Q3: "Attachment A – Scope of Work: Page 2: Item 4: Scope of Services: *"VVTA is seeking PROPOSALS from qualified firms to perform functional and cognitive assessments and make eligibility recommendations for those seeking ADA eligibility and paratransit services."* Please clarify if in-person interviews are a part of the current process. Please clarify when and how functional and cognitive assessments are completed. Can you please provide a copy of the Assessment forms currently in use?"

A3: The awarded contractor will undertake the functional and cognitive assessments before passing it along to VVTA.

Q4: "Attachment A – Scope of Work: Page 2: Item 4: Scope of Services: *"VVTA is seeking PROPOSALS from qualified firms to perform functional and cognitive assessments and make eligibility recommendations for those seeking ADA eligibility and paratransit services."* Please clarify if after a recommendation is completed, is that considered the final determination, or does the recommendation have to be reviewed by VVTA first?"

A4: VVTA will normally take awarded contractor's determination at face value until otherwise necessary. There have been some VIP reviews that have overturned eligibility determinations from the incumbant.

Q5: "Attachment A – Scope of Work: Page 2: Item 4: Scope of Services: *"Incoming calls for information and requests for eligibility applications average 233 a month."* Please provide the volume of inbound and outbound calls for the last three years"

A5: This is information that is stored by the incumbent contractor and not available to VVTA – at this time.

Q6: "Attachment A – Scope of Work: Page 2: Item 4: Scope of Services: *"Incoming calls for information and requests for eligibility applications average 233 a month."* Please provide the volume of ADA applications received for the last three years"

A6: This is information that is stored by the incumbent contractor and not available to VVTA – at this time.

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Q7: "Attachment A – Scope of Work: Page 2: Item 4: Scope of Services: *"Incoming calls for information and requests for eligibility applications average 233 a month."* In what contract year did 5-year certifications begin?"
A7: Since 2010

Q8: "Attachment A – Scope of Work: Page 3: Section 5. Certification Process: Item A: Will VVTA consider having the new ADA contractor provide any of the services listed under VVTA Duties?"
A8: No

Q9: "Attachment A – Scope of Work: Page 3: Section 5. Certification Process: Item A, VVTA Staff Duties: #1: Are VVTA staff responsible for all initial incoming calls regarding ADA applications?"
A9: Yes

Q10: "Attachment A – Scope of Work: Page 3: Section 5. Certification Process: Item A, VVTA Staff Duties: #2: Please describe which changes/updates VVTA staff are responsible for transmitting to the contractor."
A10: None – all handled by the awarded contractor.

Q11: "Attachment A – Scope of Work: Page 3: Section 5. Certification Process: Item A, VVTA Staff Duties: #4: What type of services and information are being coordinated by the VVTA Operations Services Contractor?"
A11: Certification is handled exclusively by the ADA Certs awarded contractor.

Q12: "Attachment A – Scope of Work: Page 3: Section 5, Certification Process: Item B: Obtaining an Application: Are there different applications for new applicants vs. recertification applicants?"
A12: There is one application.

Q13: "Attachment A – Scope of Work: Page 3: Section 5, Certification Process: Item B: Obtaining an Application: Can you please provide a copy of the application(s)?"
A13: The application is attached as Exhibit 1 to this Addendum.

Q14: "Attachment A – Scope of Work: Page 3: Section 5, Certification Process: Item B: Obtaining an Application: Are there more than one type of Healthcare Professional Forms?"
A14: No

Q15: "Attachment A – Scope of Work: Page 3: Section 5, Certification Process: Item B: Obtaining an Application: Can you please provide a copy of the Healthcare Professional Form(s) currently in use?"
A15: see A 13 above

Q16: "Attachment A – Scope of Work: Page 3: Section 5, Certification Process: Item B: Obtaining an Application: Do Healthcare Professionals need licensure in order to qualify to sign the forms?"
A16: B – yes.

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Q17: "Attachment A – Scope of Work: Page 3: Section 5, Certification Process: Item B: Obtaining an Application: If Forms are requested via Mail, is the Contractor responsible for the costs of mailing?"

A17: If the awarded contractor is mailing the application, then, yes.

Q18: "Attachment A – Scope of Work: Page 3: Section 5, Certification Process, Item C: Submission of Application: Please provide a breakdown of how many applications are received through each method for the last three years- Email, mail, fax, and online."

A18: No.

Q19: "Attachment A – Scope of Work: Page 3: Section 5, Certification Process, Item C: Submission of Application: Although it states that the contractor is not responsible or required to provide help in completing applications , does VVTA allow the Contractor to assist if needed?"

A19: Yes

Q20: "Attachment A – Scope of Work: Page 3: Section 5, Certification Process, Item C: If an applicant is unable to provide documentation from a Healthcare Professional, what are the next steps for them to continue the process?"

A20: There are other individuals that are able to verify the applicant's condition.

Q21: "Attachment A – Scope of Work: Page 3: Section 5, Certification Process: Item D: Review and Determination of Eligibility by Contractor: Please provide the numbers for each type of Eligibility Status category for the last three years: Unrestricted, Age-based, Permanent, Conditional, Trip-By-Trip, Temporary, Denial, and Ineligible."

A21: This is information stored with the incumbent contractor and not available to VVTA at this time.

Q22: "Attachment A – Scope of Work: Page 4-5: Section 6: Reporting and Record Keeping: Last paragraph: *"Currently original records are retained and maintained by the Contractor. Through the web- based software, VVTA staff has access to view and print the applicant's application and healthcare professional form, details of the professional evaluation, eligibility notification letters, and riders profile information."* Would VVTA consider having the new ADA Contractor use RideCo for the entire eligibility process or would they prefer that the new Contractor use their own database and transfer records electronically?"

A22: This will be negotiated with the awarded contractor.

Q23: "Attachment A – Scope of Work: Page 5-6: Section 7: Transitioning Contract: Item E: *"Reproduce a sufficient number of copies of VVTA forms and any other necessary client information and assume the responsibility for its distribution."* Please provide what VVTA forms and other materials would need to be distributed and if said forms are part of the application/determination package?"

A23: VVTA only provides what is requested by the awarded contractor.

Q24: "Attachment A – Scope of Work: Page 5-6: Section 7: Transitioning Contract: Item I: Please describe what data is to be transferred- is this referring to the Rider Profile?"

A24: This information will be negotiated with the awarded contractor.

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Q25: "Attachment A – Scope of Work: Page 5-6: Section 7: Transitioning Contract: Item N: Please confirm that the current Rider's Guide is 46 pages in length. Does this get mailed with every certification letter or can it be offered via email?"
A25: This is something that is determined by the awarded contractor.

Q26: "Attachment A – Scope of Work: Page 5-6: Section 7: Transitioning Contract: Item N: Will copies of the Rider's Guide be provided by VVTA or is the new contractor required to print copies and pay for the postage?"
A26: yes

Q27: "Attachment A – Scope of Work: Page 7: Section 10: ADA Certification Service Requirements: Item A: Staff Requirements: *"Contractor shall provide training of qualified staff, capable of performing all assessment activities under the supervision of a licensed physical therapist, occupational therapist, ophthalmologist, or certified independent living counselor."* Please clarify if the above mentioned licensed professionals are required to be a part of the new contract staffing plan."
A27: This is determined by the awarded contractor if they have the qualified staff to ensure that they can successfully manage the project and the contract.

Q28: "Attachment A – Scope of Work: Page 8: Section 2: Certification Staff: Please clarify the number of Staff/their Roles/FTE assignments of ALL current Staff, including management, certification, QA, and other staff, if applicable, on this project."
A28: See A 27 above

Q29: "Attachment A – Scope of Work: Page 8: Section 2: Certification Staff: Please clarify if incumbent ADA staff would be available to interview for the new contract and if so, which positions do they currently hold."
A29: No

Q30: "Attachment A – Scope of Work: Page 8: Section 2: Certification Staff: Please confirm that all staff assigned to this project can work remotely and in other cities."
A30: That is a determination to be made by the proposer and not VVTA.

Q31: "Attachment A – Scope of Work: Page 9: Section B: Staffing Policies: #6: Language: Please provide the amount of Applications/Determinations completed in English and Spanish and if applicable, in other languages, including what the other languages were."
A31: This will be negotiated with the awarded contractor.

Q32: "Attachment A – Scope of Work: Page 9: Section B: Staffing Policies: #6: Language: If there is enough demand, would VVTA consider having a subcontractor provide interpreter services as needed for languages other than English or Spanish."
A32: This will be negotiated with the awarded contractor

Q33: "Attachment A – Scope of Work: Page 12: ADA Application Process: Section A: Eligibility Determination: Item #1: Application Review: Please clarify if there is no Healthcare Professional Form received, can eligibility be granted based on just the application or would a phone interview be required?"
A33: That is to be determined by the awarded contractor.

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Q34: "Attachment A – Scope of Work: Page 12: ADA Application Process: Section A: Eligibility Determination: Item #2: Telephone Interview: item (a): Please clarify if there has been occurrences where a telephone interview did not provide sufficient information, either from not being able to reach the Healthcare provider, or other reasons, what would next steps include?"

A34: This is to be determined by the proposers in their certification process.

Q35: "Attachment A – Scope of Work: Page 13: Section B: Time Requirements for Processing: Item 2: (c) Determinations requiring Clarification: *"If, upon review an application is returned to the Contractor for clarification of the summary of assessment findings or basis for the recommended determination, the counting of days shall resume with the day the clarification is requested and end when the review is again completed."* Please clarify the meaning of the above statement. Does the "application review" indicate: a) That VVTA reviews an application before the Contractor receives it? b) Or is the determination sent to VVTA for final review and approval before it can be considered approved and officially "determined"."

A35: This is all the responsibility of the incumbent and will be the responsibility of the awarded contractor.

Q36: "Please provide a description of whichever process is correct from Q35 - A or b above. If "b" is correct, please provide the average amount of days it takes for VVTA to provide approval."

A36: See A 35

Q37: "Can you provide the budget for this 5-year contract."

A37: $150,000.00

Q38: "What is the page limit for this proposal and would that page limit include required forms and resumes."

A38: Try to keep your proposal under 200 pages

As stated in the RFP, all addenda must be acknowledged. Please use the form included in Attachment E, page 11, of the RFP to acknowledge receipt of this addendum. Failure to acknowledge any addenda to this RFP may be a cause to deem Proposer "Non-Responsive."

Application for ADA Paratransit Service

[redacted]

How To Complete Application

Applicants for ADA Paratransit Service must complete an application form and a Professional Verification Form. All questions must be answered. INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED. The following professionals can complete the verification form on your behalf: Physician (MD / DO), Psychologist, Psychiatrist, Physiatrist (i.e. Dept. of Rehab) Physician Assistant, Physical or Occupational Therapist (or assistant), Registered Nurse, Rehabilitation Counselor, O&M Specialist, Optometrist / Ophthalmologist, Recreation Therapist, Special Education Teacher / Counselor, Social Worker (MSW), Case Manager (i.e. Inland Regional Center / Department of Behavioral Health) , Chiropractor, Certified Nursing Assistants, Probation / Parole Officers, or Respiratory Therapist. If you have any questions or need assistance in completing this application, please call [redacted]. Upon receipt of a completed application, including the Professional Verification Form, [redacted] will make a determination regarding your eligibility for ADA Paratransit Service.

Accessibility Features of the Bus

ATTENTION VVTA CUSTOMERS: It is the responsibility of the rider to be on a paved area for pick up as VVTA buses and vans travel on pavement only, not dirt roads. Victor Valley Transit Authority's fixed route buses are 100% accessible and feature: Kneeling feature, Lifts or low floor entry ramps for anyone who needs it, Designated Seating, Stop Announcements, Hand Rails.

ADDRESS / FAX / EMAIL

Please forward both COMPLETED forms to:

Personal data

First name: [redacted]
Middle name:
Last name: [redacted]
Sex: [redacted]
Primary language: [redacted]
TDD: [redacted]
Date of birth: [redacted]
Place of birth:
E-mail address:
Format: [redacted]
User name: [redacted]
Day phone: [redacted]
Evening phone: (111) 111-1111
Mobile:

Mailing address

[redacted]

Home address

Street#: [redacted] Street: [redacted] Apt#:
City: [redacted] State: [redacted]

Application ID: [redacted]

Emergency contact

1. Do you wish to provide your emergency contact information? ☒ Yes ☐ No

[redacted]

First name: [redacted] Middle name:
Last name: [redacted] E-mail address: [redacted]
Day phone: 111-111-1111 Evening phone: □□□-□□□-□□□□
Mobile phone: 111-111-1111 Relationship: Family
Street#: [redacted] Street: [redacted] Apt#:
City: [redacted] State: [redacted]

2. Please provide your Medi-Cal number if applicable_____

Application ID: [redacted]

Applicant's medical conditions

3. What is your medical condition(s) / Disability?

[redacted]

4. Date of onset / when your disability first began:

5. Are you currently receiving treatment? If yes, please check all that apply.

- ☐ None
- ☐ Physical Therapy
- ☐ Chemotherapy
- ☐ Radiation Therapy
- ☐ Dialysis
- ☐ Psychotherapy
- ☐ Non-Weight-Bearing Immobilization
- ☐ Weight-Bearing Immobilization
- ☐ Travel Training
- ☐ Rehabilitation Program
- ☐ Surgery
- ☐ New Medications
- ☐ Medications
- ☐ Convalescence
- ☐ Other

6. If yes, how long will you be receiving treatment:

- ☐ 1 - 6 months
- ☐ 6 - 12 months
- ☐ Over a year
- ☐ Over Five Years

7. Please read the following statements and check the one that best describes your disability

- ☐ I have a temporary disability and will only need paratransit service until I recover.
- ☐ I have difficulty remembering all of the things I have to do to use city Bus.
- ☐ I am able to ride city Bus independently.
- ☐ I have a visual disability which prevents me from using city Bus.
- ☐ I have a disability(s) that causes me to have Good day(s) /Bad Day(s).
- ☐ I can never use city Bus by myself.
- ☐ I can use city Bus for some trips but not others.
- ☐ I believe I can learn to ride city Bus if some one taught me.

8. Do you currently use a mobility device when going places? ☒ Yes ☐ No

9. If yes, check applicable in the list:

[redacted]

[redacted]

- ☐ Power/Electric Wheelchair
- ☒ Manual Wheelchair
- ☐ Scooter
- ☐ Sport Wheelchair
- ☐ Walker
- ☐ Service Animal
- ☐ Prosthesis
- ☐ Cane
- ☐ White Cane
- ☐ Crutches
- ☐ Portable Oxygen
- ☐ None
- ☐ Other
- ☐ Communication Board
- ☐ Leg Braces
- ☐ Picture/Alphabet Board
- ☐ Segway

10. Is your scooter/wheelchair wider than 30"?

☐ Yes ☒ No ☐ I don't know ☐ N/A

11. Is your scooter/wheelchair longer than 48"?

☐ Yes ☒ No ☐ I don't know ☐ N/A

12. Is the total combined weight of you and your mobility device more than 600 lbs?

☐ Yes ☒ No ☐ I don't know ☐ N/A

13. Description:

[redacted]

Application ID: [redacted]

Fixed Routes

14. If you use the city bus independently, specify your routes:

First route

Destination name: ----------

Routes: ----------

Street#: ---------- Street: ----------

City: ----------

☐ With transfer?

Second route

Destination name: ----------

Routes: ----------

Street#: ---------- Street: ----------

City: ----------

☐ With transfer?

[redacted]

15. How many blocks are there from your home to nearest bus stop?

☐ 1 - 5 ☐ 6 - 10 ☐ 11 - 15

☐ 16 or more ☐ Don't Know

[redacted]

16. When was the last time you independently used city bus?

☐ In the past week ☐ In the past month ☐ In the past year
☐ Longer than one year ago ☐ Never

17. Are there certain routes / trips when you can use the city bus?

☐ Yes ☐ No ☐ Sometimes
☐ Don't Know

If you have chosen Yes/Sometimes, please explain:

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18. Are you able to wait for city Bus?

☐ Yes ☐ No ☐ Sometimes
☐ Don't Know

If you have chosen No/Sometimes, please explain:

Personal Care Attendant

19. Do you need a Personal Care Attendant? ☒ Yes ☐ No

Checking yes on Personal Care Attendant means you need someone to travel with you in order to successfully complete a trip. A PCA is not provided to you but is your responsibility to bring one and they travel for free.

20. How would you describe the terrain where you live (e.g. Flat, hilly, dirt roads, lack of sidewalks):

21. Would you be interested in participating in travel training to ride a bus because the bus is cheaper and more convenient?

☐ Yes ☐ No

Application ID: [redacted]

22. If you have a hearing problem, would it prevent you from using a Bus?

☐ Yes ☐ No

If you have chosen Yes, please explain:

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23. If you have a vision problem, would it prevent you from using a Bus?

☐ Yes ☐ No

If you have answered Yes, please explain:

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24. If you have a memory problem, would it prevent you from using a Bus?

☐ Yes ☐ No

If you have chosen yes, please explain:

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25. If you have a balance problem, would it prevent you from using a Bus?

☐ Yes ☐ No

If you have chosen yes, please explain:

[redacted]

26. If you have a breathing problem, would it prevent you from using a Bus?

☐ Yes ☐ No

If you answered Yes, please explain:

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27. Would you have a problem independently crossing a street?

☐ Yes ☐ No

If you have chosen yes, please explain:

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28. Have you ever been lost when traveling alone?

☐ Yes ☐ No

If you have chosen yes, please explain how did you find your way back:

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29. How far can you walk (using mobility device if applicable) or wheel without resting?

30. The following list are common barriers which prevent people from using the bus. Do any of these barriers apply to you?

☐ Cold	☐ Heat	☐ Rain
☐ Night blindness	☐ Snow	☐ Light sensitivity(Sunny,Overcast,etc)
☐ Lack of sidewalks	☐ Lack of curb cuts	☐ Uneven travel path(dirt road, pot holes etc.)
☐ Hill	☐ Bus stop not accessible	☐ Unable to walk/wheel 50 feet(1 block)
☐ Air pollution (Bus fumes, allergies)	☐ Good/Bad Day	☐ Unable to walk/wheel 1/4 mile (3 blocks)
☐ Lack of strength and endurance (hyper fatigue)	☐ Unable to transfer buses	☐ Unable to walk/wheel 3/4 mile (9 blocks)
☐ None		

31. Do you have a home healthcare provider?

☐ Yes ☐ No

[redacted]

By signing this term I understand: I am giving consent fo[redacted] and Victor Valley Transit Authority to use and disclose my protecte health information for the following purposes and activities:

1) To transfer information to transportation providers and mobility services.
2) Permission to contact your healthcare provider to verify your disability and treatment plan for purposes of paratransit eligibility.
3) The information provided is true and correct to the best of my knowledge.
4) I agree to inform Victor Valley Transit Authority when there are significant changes in my mobility.

[redacted] & Victor Valley Transit Authority appreciate your cooperation in this process and assure you that your protected health information will be managed through strict HIPAA (Health Insurance Portability and Accountability Act) compliant policies and procedures

I realize that I have the right to review and receive a copy of this consent form before signing. I understand that I may revoke this consent form at any time by notifying both [redacted] and Victor Valley Transit Authority in writing of my intent to revoke this consent form, exce that if I do notify Victor Valley Transit Authority in writing of my intent to revoke this consent form, such revocation shall not have any effe on any information used or disclosed by Victor Valley Transit Authority for transit and mobility services. I hereby certify that the informatic provided during the eligibility process is true and correct to the best of my knowledge. I understand that misrepresentation in this process presented during my assessment may result in denial of priviledges to use paratransit services. I understand that I have the right to reque

[redacted]

that Victor Valley Transit Authority restrict how protected health information is used or disclosed for transit and mobility services. I understand that Victor Valley Transit Authority is not required to agree with my requested restrictions. I understand that if they do agree w my request that they will be bound by their agreement.

Signature:_____ Date:_____

Do you have any notes or restrictions on your release?

[redacted]

VICTOR VALLEY TRANSIT

HEALTHCARE PROFESSIONAL VERIFICATION

FOR PROFESSIONAL USE ONLY

Application ID [redacted]

HEALTHCARE PROFESSIONAL VERIFICATION

Your client/patient is applying for the Americans with Disabilities Act Paratransit service. The criterion used for determining eligibility is based on one's functional ability to independently use accessible public transportation (bus and rail). There are physical, mental, visual ski required to access public buses and hopefully you can help document your client/ patient's abilities. The following professionals can complete the verification form on your behalf: Physician (MD / DO), Psychologist, Psychiatrist, Physiatrist (i.e. Dept. of Rehab) Physician Assistant, Physical or Occupational Therapist (or assistant), Registered Nurse, Rehabilitation Counselor, O&M Specialist, Optometrist / Ophthalmologist, Recreation Therapist, Special Education Teacher / Counselor, Social Worker (MSW), Case Manager (i.e. Inland Regional Center / Department of Behavioral Health) , Chiropractor, Certified Nursing Assistants, Probation / Parole Officers, or Respiratory Therapist. Your participation is vital as incomplete applications will be deemed ineligible and your client / patient will not be able to use the ADA paratransit service.We value your input and respectfully request a response ASAP.

The information shared will be protected per the requirements identified in the Health Insurance Portability and Accountability Act (HIPAA) and your patient/client has agreed to allow VVTA and its eligibility contractor, [redacted] to contact you for this information via the application. If you have any questions or comments please do not hesitate to contact us [redacted]

ADDRESS / FAX / EMAIL

Please forward both COMPLETED forms to:

[redacted]

or FAX to: [redacted]

[redacted]

1. Name of patient / Client

Your professional information

First name: [redacted] Middle name: _____

Last name: [redacted] Professional license#: _____

Profession: [redacted] E-mail address: _____

Day phone: [redacted] Mobile phone: ☐☐☐-☐☐☐-☐☐☐☐

Address

Street#: [redacted] Street: [redacted] Apt#: _____

City: [redacted] State: [redacted]

[redacted]

2. I understand the purpose of this verification form is to document my clients' / patients' functional abilities to use a public bus and to apply for Victor Valley's Paratransit Service. By signing this form, I certify that, to the best of my knowledge, the information provided in this form is true and correct. (sign your name below or if completing online, please check the box)

3. Title_____

4. Date_____

Application ID: [redacted]

5. Please list the diagnosis you are treating your client / patient for and any other diagnosis that your client may have

[redacted]

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6. Please indicate which of the following category most limits your client/patient.
You can check more than one category if both disabilities limit your client's/patient's independence and mobility.

- ☐ Mental
- ☐ Physical
- ☐ Visual

If you have chosen Physical , please choose categories:

- ☐ Cardio vascular
- ☐ Gastrointestinal disorders
- ☐ Geriatric disorders
- ☐ Infectious diseases / immunology
- ☐ Neurologic disorders
- ☐ Oncology and hematology
- ☐ Organ failure / transplant / diabetes
- ☐ Orthopedic conditions
- ☐ Other
- ☐ Pediatric disorders
- ☐ Pulmonary disorders

[redacted]

7. Date of onset or date patient began services

8. Which statement best describes your patient's condition?

- ☐ Being treated and hopes to improve
- ☐ Permanent condition that is not expected to change
- ☐ Disease is advanced and considered terminal
- ☐ Condition should not interfere with independent bus usage
- ☐ None of the above

9. Treatment plan with start date and anticipated completion date

10. If the applicant takes medications, how does it affect their ability to travel?

[redacted]

11. Have you ever prescribed or are you aware of device your client / patient currently uses?

- ☐ None
- ☐ Cane
- ☐ Power / Electric Wheelchair
- ☐ Crutches
- ☐ Manual Wheelchair
- ☐ Communication Board
- ☐ Scooter
- ☐ White Cane
- ☐ Walker
- ☐ Leg Braces
- ☐ Sport Wheelchair
- ☐ Portable Oxygen
- ☐ Service Animal
- ☐ Picture/Alphabet Board
- ☐ Prosthesis
- ☐ Segway
- ☐ Other

12. Are your client's / patients symptoms episodic?

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

---

13. Are you aware of any challenges your client / patient has with strength and endurance or balance?

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

---

14. Do you think your patient/client could independently ambulate / wheel 3/4 of mile (with a mobility device and brief rest periods if needed)?

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Do not know

If you have chosen No/Sometimes, please elaborate:

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15. Are you aware of any challenges your client / patient has with memory?

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

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16. Are you aware of any challenges your client / patient has with breathing?

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

---

17. Are you aware of any challenges your client / patient has with crossing streets?

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

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18. Are you aware of any challenges your client / patient has with ambulating on hills?

☐ Yes ☐ No ☐ Sometimes

☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

---

19. Do you have any safety concerns for your client / patient in using a bus by themselves (e.g. compromised immune system, panic attacks, cognitive deficits, risk of falling etc)?

☐ Yes ☐ No ☐ Sometimes

☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

---

20. Are you aware if weather has an adverse impact on your client's / patient's abilities?

☐ Yes ☐ No ☐ Sometimes

☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

---

21. Are you aware of any visual impairment that may challenge your client / patient in using the public transportation system?

☐ Yes ☐ No ☐ Sometimes

☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

---

22. Are you aware of any hearing impairment that may challenge your client / patient in using the public transportation system?

☐ Yes ☐ No ☐ Sometimes

☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

---

23. Are you aware of any challenges your client / patient has with their activities of daily living?

☐ Yes ☐ No ☐ Sometimes

☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

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24. Are you aware of any inappropriate social behavior exhibited by your client / patient?

☐ Yes ☐ No ☐ Sometimes

☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

[redacted]

25. Do you have any additional comments that may help document your client's/patient's abilities/challenges in getting to, using, and commuting on a bus?

☐ Yes ☐ No ☐ Sometimes

☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

Personal information

Application Form

Personal data

First name: [redacted] Middle name:

Last name: [redacted] Sex: [redacted]

Primary language: [redacted] TDD: [redacted]

Date of birth: [redacted] Place of birth:

E-mail address: Format: [redacted]

User name: [redacted]

Day phone: [redacted] Evening phone: (111) 111-1111

Mobile:

Mailing address

[redacted] CA [redacted]

Home address

Street# [redacted] Street: [redacted] Apt#:

City: [redacted] State: [redacted]

Emergency contact

Do you wish to provide your emergency contact information? ☒ Yes ☐ No

First name: [redacted] Middle name:

Last name: [redacted] E-mail address: [redacted]

Day phone: 111-111-1111 Evening phone: □□□-□□□-□□□□

Mobile phone: 111-111-1111 Relationship: [redacted]

Street# [redacted] Street: [redacted] Apt#:

City: [redacted] State: [redacted]

Healthcare Professional personal information

Application Form

Verification Form

Your professional information

First name: [redacted] Middle name:

[redacted]

[redacted]

Last name: [redacted]

Professional license#:

Profess[redacted]

E-mail address:

Day phone: [redacted]

Mobile phone:

□□□-□□□-□□□□

Address

Street# [redacted] Street: [redacted] Apt#:

City: [redacted] State: [redacted]

Name of patient / Client

Medical condition

Application Form

What is your medical condition(s) / Disability?

[redacted]

Verification Form

Please list the diagnosis you are treating your client / patient for and any other diagnosis that your client may have

[redacted]

Please indicate which of the following category most limits your client/patient.
You can check more than one category if both disabilities limit your client's/patient's independence and mobility.

☐ Mental ☐ Physical ☐ Visual

If you have chosen Physical , please choose categories:

☐ Cardio vascular

☐ Gastrointestinal disorders

☐ Geriatric disorders

☐ Infectious diseases / immunology

☐ Neurologic disorders

☐ Oncology and hematology

☐ Organ failure / transplant / diabetes

☐ Orthopedic conditions

☐ Other

☐ Pediatric disorders

☐ Pulmonary disorders

Evaluation

Opinion about medical condition

[redacted]

[redacted]

Mobility Device

Application Form

Do you currently use a mobility device when going places?

☒ Yes ☐ No

If yes, check applicable in the list:

☐ Power/Electric Wheelchair
☒ Manual Wheelchair
☐ Scooter
☐ Sport Wheelchair
☐ Walker
☐ Service Animal
☐ Prosthesis
☐ Cane
☐ White Cane
☐ Crutches
☐ Portable Oxygen
☐ None
☐ Other
☐ Communication Board
☐ Leg Braces
☐ Picture/Alphabet Board
☐ Segway

Is your scooter/wheelchair wider than 30"?

☐ Yes ☒ No ☐ I don't know ☐ N/A

Is your scooter/wheelchair longer than 48"?

☐ Yes ☒ No ☐ I don't know ☐ N/A

Is the total combined weight of you and your mobility device more than 600 lbs?

☐ Yes ☒ No ☐ I don't know ☐ N/A

Description:

[redacted]

Verification Form

Have you ever prescribed or are you aware of device your client / patient currently uses?

☐ None
☐ Power / Electric Wheelchair
☐ Manual Wheelchair
☐ Scooter
☐ Walker
☐ Sport Wheelchair
☐ Service Animal
☐ Prosthesis
☐ Other
☐ Cane
☐ Crutches
☐ Communication Board
☐ White Cane
☐ Leg Braces
☐ Portable Oxygen
☐ Picture/Alphabet Board
☐ Segway

[redacted]

[redacted]

Evaluation

Determination

- ☐ Does not appear to prevent applicant from using the bus
- ☐ Does appear to prevent applicant from using the bus
- ☐ Appears to inconvenience applicant from using the bus
- ☐ Unable to make determination due to Inconsistent information

Memory

Application Form

If you have a memory problem, would it prevent you from using a Bus?

- ☐ Yes
- ☐ No

If you have chosen yes, please explain:

Verification Form

Are you aware of any challenges your client / patient has with memory?

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

Evaluation

This determination

- ☐ Does not appear to prevent applicant from using the bus
- ☐ Does appear to prevent applicant from using the bus
- ☐ Appears to inconvenience applicant from using the bus
- ☐ Unable to make determination due to Inconsistent information

Balance

Application Form

If you have a balance problem, would it prevent you from using a Bus?

- ☐ Yes
- ☐ No

If you have chosen yes, please explain:

Verification Form

Evaluation

This determination

- ☐ Does not appear to prevent applicant from using the bus
- ☐ Does appear to prevent applicant from using the bus
- ☐ Appears to inconvenience applicant from using the bus
- ☐ Unable to make determination due to Inconsistent information

[redacted]

[redacted]

[redacted]

Application Form

If you have a breathing problem, would it prevent you from using a Bus?

☐ Yes ☐ No

If you answered Yes, please explain:

Verification Form

Are you aware of any challenges your client / patient has with breathing?

☐ Yes ☐ No

☐ Sometimes ☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

Evaluation

This determination

☐ Does not appear to prevent applicant from using the bus

☐ Does appear to prevent applicant from using the bus

☐ Appears to inconvenience applicant from using the bus

☐ Unable to make determination due to Inconsistent information

Street Crossing

Application Form

Would you have a problem independently crossing a street?

☐ Yes ☐ No

If you have chosen yes, please explain:

Verification Form

Are you aware of any challenges your client / patient has with crossing streets?

☐ Yes ☐ No

☐ Sometimes ☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

Evaluation

This determination

☐ Does not appear to prevent applicant from using the bus

☐ Does appear to prevent applicant from using the bus

☐ Appears to inconvenience applicant from using the bus

☐ Unable to make determination due to Inconsistent information

Navigating Public Bus System

Application Form

Are you able to wait for city Bus?

☐ Yes ☐ No

☐ Sometimes ☐ Don't Know

If you have chosen No/Sometimes, please explain:

Verification Form

Do you have any safety concerns for your client / patient in using a bus by themselves (e.g. compromised immune system, panic attacks, cognitive deficits, risk of falling etc)?

☐ Yes ☐ No

☐ Sometimes ☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

[redacted]

Have you ever been lost when traveling alone?

☐ Yes ☐ No

If you have chosen yes, please explain how did you find your way back:

Are you aware of any challenges your client / patient has with their activities of daily living?

☐ Yes ☐ No

☐ Sometimes ☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

Are you aware of any inappropriate social behavior exhibited by your client / patient?

☐ Yes ☐ No

☐ Sometimes ☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

Evaluation

This determination

☐ Does not appear to prevent applicant from using the bus

☐ Does appear to prevent applicant from using the bus

☐ Appears to inconvenience applicant from using the bus

☐ Unable to make determination due to Inconsistent information

Hearing

Application Form

If you have a hearing problem, would it prevent you from using a Bus?

☐ Yes ☐ No

If you have chosen Yes, please explain:

Verification Form

Are you aware of any hearing impairment that may challenge your client / patient in using the public transportation system?

☐ Yes ☐ No

☐ Sometimes ☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

Evaluation

This determination

☐ Does not appear to prevent applicant from using the bus

☐ Does appear to prevent applicant from using the bus

☐ Appears to inconvenience applicant from using the bus

☐ Unable to make determination due to Inconsistent information

Seeing

Application Form

If you have a vision problem, would it prevent you from using a Bus?

☐ Yes ☐ No

If you have answered Yes, please explain:

Verification Form

Are you aware of any visual impairment that may challenge your client / patient in using the public transportation system?

☐ Yes ☐ No

☐ Sometimes ☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

[redacted]

Evaluation

This determination

- ☐ Does not appear to prevent applicant from using the bus
- ☐ Does appear to prevent applicant from using the bus
- ☐ Appears to inconvenience applicant from using the bus
- ☐ Unable to make determination due to Inconsistent information

Ambulating

Application Form

How many blocks are there from your home to nearest bus stop?

- ☐ 1 - 5
- ☐ 6 - 10
- ☐ 11 - 15
- ☐ 16 or more
- ☐ Don't Know

How far can you walk (using mobility device if applicable) or wheel without resting?

Verification Form

Do you think your patient/client could independently ambulate / wheel 3/4 of mile (with a mobility device and brief rest periods if needed)?

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Do not know

If you have chosen No/Sometimes, please elaborate:

Are you aware of any challenges your client / patient has with ambulating on hills?

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

Are you aware of any challenges your client / patient has with strength and endurance or balance?

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

Evaluation

This determination

- ☐ Does not appear to prevent applicant from using the bus
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Disability

Application Form

Date of onset / when your disabilityfirst began:

Verification Form

Date of onset or date patient began services

[redacted]

If yes, how long will you be receiving treatment:

- ☐ 1 - 6 months
- ☐ 6 - 12 months
- ☐ Over a year
- ☐ Over Five Years

Please read the following statements and check the one that best describes your disability

- ☐ I have a temporary disability and will only need paratransit service until I recover.
- ☐ I have difficulty remembering all of the things I have to do to use city Bus.
- ☐ I am able to ride city Bus independently.
- ☐ I have a visual disability which prevents me from using city Bus.
- ☐ I have a disability(s) that causes me to have Good day(s) /Bad Day(s).
- ☐ I can never use city Bus by myself.
- ☐ I can use city Bus for some trips but not others.
- ☐ I believe I can learn to ride city Bus if some one taught me.

Are you currently receiving treatment? If yes, please check all that apply.

- ☐ None
- ☐ Physical Therapy
- ☐ Chemotherapy
- ☐ Radiation Therapy
- ☐ Dialysis
- ☐ Psychotherapy
- ☐ Non-Weight-Bearing Immobilization
- ☐ Weight-Bearing Immobilization
- ☐ Travel Training
- ☐ Rehabilitation Program
- ☐ Surgery
- ☐ New Medications
- ☐ Medications
- ☐ Convalescence
- ☐ Other

Which statement best describes your patient's condition?

- ☐ Being treated and hopes to improve
- ☐ Permanent condition that is not expected to change
- ☐ Disease is advanced and considered terminal
- ☐ Condition should not interfere with independent bus usage
- ☐ None of the above

Treatment plan with start date and anticipated completion date

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Are your client's / patients symptoms episodic?

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

If the applicant takes medications, how does it affect their ability to travel?

Evaluation

This determination

- ☐ Does not appear to prevent applicant from using the bus
- ☐ Does appear to prevent applicant from using the bus
- ☐ Appears to inconvenience applicant from using the bus
- ☐ Unable to make determination due to Inconsistent information

Evaluation

Choose treatment plan for the applicant:

- ☐ None
- ☐ Chemotherapy
- ☐ Dialysis
- ☐ Non-Weight-Bearing Immobilization
- ☐ Travel Training
- ☐ Surgery
- ☐ Medications
- ☐ Other
- ☐ Physical Therapy
- ☐ Radiation Therapy
- ☐ Psychotherapy
- ☐ Weight-Bearing Immobilization
- ☐ Rehabilitation Program
- ☐ New Medications
- ☐ Convalescence

Evaluation

Choose treatment duration:

- ☐ 1 - 3 months
- ☐ 6 - 9 months
- ☐ Over a year
- ☐ 3 - 6 months
- ☐ 9 - 12 months
- ☐ N/A

Barriers

Application Form

How would you describe the terrain where you live (e.g. Flat, hilly, dirt roads, lack of sidewalks):

Verification Form

Are you aware if weather has an adverse impact on your client's / patient's abilities?

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

[redacted]

The following list are common barriers which prevent people from using the bus. Do any of these barriers apply to you?

- ☐ Cold
- ☐ Heat
- ☐ Rain
- ☐ Night blindness
- ☐ Snow
- ☐ Light sensitivity(Sunny,Overcast,etc)
- ☐ Lack of sidewalks
- ☐ Lack of curb cuts
- ☐ Uneven travel path(dirt road, pot holes etc.)
- ☐ Hill
- ☐ Bus stop not accessible
- ☐ Unable to walk/wheel 50 feet(1 block)
- ☐ Air pollution (Bus fumes, allergies)
- ☐ Good/Bad Day
- ☐ Unable to walk/wheel 1/4 mile (3 blocks)
- ☐ Lack of strength and endurance (hyper fatigue)
- ☐ Unable to transfer buses
- ☐ Unable to walk/wheel 3/4 mile (9 blocks)
- ☐ None

Evaluation

This determination

- ☐ Does not appear to prevent applicant from using the bus
- ☐ Does appear to prevent applicant from using the bus
- ☐ Appears to inconvenience applicant from using the bus
- ☐ Unable to make determination due to Inconsistent information

Evaluation

Choose which barriers may prevent applicant from using the bus:

- ☐ Cold
- ☐ Heat
- ☐ Rain
- ☐ Night blindness
- ☐ Snow
- ☐ Light sensitivity(Sunny,Overcast,etc)
- ☐ Lack of side walks
- ☐ Lack of curb cuts
- ☐ Uneven travel path(dirt road, pot holes etc.)
- ☐ Hill
- ☐ Bus stop not accessible
- ☐ Unable to walk/wheel 50 feet(1 block)
- ☐ Air pollution (Bus fumes, allergies)
- ☐ Good/Bad Day
- ☐ Unable to walk/wheel 1/4 mile (3 blocks)
- ☐ Lack of strength and endurance (hyper fatigue)
- ☐ Unable to transfer buses
- ☐ Unable to walk/wheel 3/4 mile (9 blocks)
- ☐ None

[redacted]

Bus Usage / Travel

Application Form

Fixed Routes

If you use the city bus independently, specify your routes:

First route

Destination name: ----------

Routes: ----------

Street#: ------ Street: ----------

City: ----------

☐ With transfer?

Second route

Destination name: ----------

Routes: ----------

Street#: ------ Street: ----------

City: ----------

☐ With transfer?

Would you be interested in participating in travel training to ride a bus because the bus is cheaper and more convenient?

☐ Yes ☐ No

Are there certain routes / trips when you can use the city bus?

☐ Yes ☐ No

☐ Sometimes ☐ Don't Know

If you have chosen Yes/Sometimes, please explain:

When was the last time you independently used city bus?

☐ In the past week ☐ In the past month

☐ In the past year ☐ Longer than one year ago

☐ Never

Verification Form

Do you have any additional comments that may help document your client's/patient's abilities/challenges in getting to, using, and commuting on a bus?

☐ Yes ☐ No

☐ Sometimes ☐ Do not know

If you have chosen Yes/Sometimes, please elaborate:

[redacted]

Evaluation

This determination

- ☐ Does not appear to prevent applicant from using the bus
- ☐ Does appear to prevent applicant from using the bus
- ☐ Appears to inconvenience applicant from using the bus
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Miscellaneous

Application Form	Verification Form

Do you have a home healthcare provider?

- ☐ Yes
- ☐ No

Print

[redacted]