
HOW TO APPLY FOR ADA PARATRANSIT CERTIFICATION

Access-a-Ride is RTD's complementary paratransit service. Like the regular bus, it is shared ride service. Eligibility for Access-a-Ride service is determined by the impact a disability or disabling condition has on one's ability to use bus/rail service, not on the presence of a disabling condition. Eligibility is established under the guidelines provided by the federal government.

Similar to regular bus service, there may be multiple stops en route to your destination.

How to apply in 4 easy steps

1. Complete the enclosed Application form.
2. Download the Medical Verification Form. Sign the Authorization for Release of Information and provide the form for completion to your licensed Medical Provider familiar with your disability.
3. Return both parts of the *completed forms* to RTD via USPS at:

RTD

c/o Access-a-Ride

1660 BLAKE ST

DENVER, CO 80202 OR fax it to 303-299-2169

Once RTD has reviewed the completed documents, they will be sent to our assessment center, and you will be contacted to schedule via an automated call system.

4. Participate in an in-person certification appointment. RTD will provide transportation to this appointment if needed. ID photos will be taken.

Please let us know if you need translation of interpretation services for this appointment.

What to do on the day of your certification appointment

1. Wear clothing appropriate for the weather.
2. Bring the mobility aids that you primarily use (or will use) on public transportation.
Note: our vehicles can accommodate a combined weight of up to 800 pounds.
3. Bring a photo ID card.
4. Bring someone to assist you with personal care tasks if needed.
5. If you use oxygen, bring enough for at least 3 hours.
6. Bring a snack if you feel you might need one.
7. Bring medications that you will need during the time you are away (up to 3 hrs).

Applications not completed within 90 days of submission will be considered withdrawn.

Important note: All determinations are made based on the information gathered from your application, medical verification form, and your assessment. Applicants who wish to appeal their eligibility determination will be provided with information on how to make an appeal when their assessment results are mailed.

ADA Paratransit Certification Application



ADA PARATRANSIT CERTIFICATION APPLICATION. (New customers)

(Unanswered questions may result in a delay in processing) Please keep all answers inside the provided text boxes

Name:

Address:

Apt:

City:

State:

Zip:

County:

Name of Apartment/Facility:

Primary Phone:

☐ Home

☐ Cell

☐ Work

Secondary Phone:

☐ Home

☐ Cell

☐ Work

E-Mail:

Birth Date:

Gender: ☐ Male ☐ Female ☐

Pronouns Used: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs

Mailing Address (if different)

Address:

Apt:

City:

State:

Zip:

Primary Language

Will you need translation? ☐ Yes ☐ No

Need written information in a different format? Indicate preference:

Local Emergency Contact

Name:

Relationship:

Primary Phone:

☐ Home

☐ Cell

☐ Work

Secondary Phone:

☐ Home

☐ Cell

☐ Work

Is someone assisting you with this application? (Name and contact information)

My preferred communication is via: ☐ Phone ☐ Text ☐ Email

I wish to receive recorded pick up reminders the night before the trip: ☐ Yes ☐ No

I wish to receive recorded pick up information when pick up is imminent: ☐ Yes ☐ No

☐ I understand that paratransit service is not point-to-point transportation, but shared ride public transportation. Service on Access-a-Ride is only available when fixed route bus service is available.

(initial here)

CURRENT TRAVEL

How do you currently travel outside your home?

☐ Access-a-Ride ☐ Access-on-Demand ☐ Uber/Lyft ☐ Friends or family

☐ I use fixed route bus and rail services regularly.

Primary routes used:

- ☐ I use fixed route bus and rail to go the following places:
- ☐ I need help using the fixed route bus and rail for the following tasks:
- ☐ I can never use regular fixed route bus and rail because:

When was the last time you used the fixed route bus/rail?

How far is it from your home to the nearest bus stop?

HEALTH STATUS:

How do your health-related conditions currently **PREVENT** you from using regular public transit without the help of another person?

Do the effects of these conditions vary from day to day? ☐ Yes ☐ No

Do your health-related conditions inhibit your ability to perform self-care tasks or tasks related to living independently? ☐ Yes ☐ No

Which of these mobility aids do you use when you leave your home? (Check all that apply)

- | | | |
|--|-------------------------------------|---|
| ☐ None | ☐ Cane | ☐ Manual wheelchair |
| ☐ Communication board | ☐ Prosthesis | ☐ Extra-large wheelchair |
| ☐ Portable oxygen | ☐ Crutches | ☐ Power wheelchair |
| ☐ White cane | ☐ Walker | ☐ Power scooter |
| ☐ Service animal | ☐ Other: | |

****PLEASE bring your primary mobility device to your certification appointment. You may be required to return with your device if you do not bring it to your appointment.****

TRAVEL RELATED SKILLS:

Are you able to perform the following tasks?

- | | | | |
|---|------------------------------|-----------------------------|------------------------------------|
| Read a bus and/or rail schedule? | ☐ Yes | ☐ No | ☐ Sometimes |
| Use a phone app to assist with trip planning? | ☐ Yes | ☐ No | ☐ Sometimes |
| Contact Customer Care to help with trip planning? | ☐ Yes | ☐ No | ☐ Sometimes |
| Manage fare media? | ☐ Yes | ☐ No | ☐ Sometimes |
| Recognize landmarks/locate your destination? | ☐ Yes | ☐ No | ☐ Sometimes |
| Follow directions in an emergency? | ☐ Yes | ☐ No | ☐ Sometimes |
| Determine a new plan when you make a mistake? | ☐ Yes | ☐ No | ☐ Sometimes |

Please explain no/sometimes answers:

When traveling in the community, are you able to:

- | | | | |
|---------------------------------------|------------------------------|-----------------------------|------------------------------------|
| Cross a busy intersection? | ☐ Yes | ☐ No | ☐ Sometimes |
| Travel up/down hills? | ☐ Yes | ☐ No | ☐ Sometimes |
| Travel in areas without curb cuts? | ☐ Yes | ☐ No | ☐ Sometimes |
| Travel at night? | ☐ Yes | ☐ No | ☐ Sometimes |
| Travel in cold weather? | ☐ Yes | ☐ No | ☐ Sometimes |
| Travel in hot weather? | ☐ Yes | ☐ No | ☐ Sometimes |
| Travel in bright light conditions? | ☐ Yes | ☐ No | ☐ Sometimes |
| Travel when it is raining or snowing? | ☐ Yes | ☐ No | ☐ Sometimes |
| Have you ever had travel training? | ☐ Yes | ☐ No | |

Please explain no/sometimes answers:

How far are you able to travel when in the community?

Eligibility for paratransit service is set forth by the Americans with Disabilities Act of 1990 (Section 37.123 (3)):

1. *Based on an inability to get to and from a bus stop or on and off a lift-equipped fixed-route bus by yourself.*
2. *Having a disability that prohibits you from completing fixed-route bus.*

Please review the following information: (and check once read)

- ☐ I understand that the medical verification form is a required part of this application and must be completed by one of my licensed providers.
- ☐ I understand that an in-person interview and assessment of my mobility needs is required as part of this application process. Access-a-Ride will provide transportation to that appointment if needed.
- ☐ Incomplete forms or forms without signature of **applicant** or **legal guardian** will not be processed until completed. Please check the forms for completeness prior to submission.
- ☐ Travel training services are available through the certification center for those wishing to learn how to use fixed route bus and rail service.

☐ I certify that the information provided in this application is true and correct.

☐ I understand that falsification of information could result in loss of Access-a-Ride services.

Forms without signature will delay processing. Incomplete applications may be withdrawn after 90 days.

Signature of Applicant or Legal Representative

Date

Verbal consent is not a substitute for the applicants signature in most cases (02/2023)

Please print and sign this form before submitting to the address listed on page one.

Professional Medical Verification Form for ADA Paratransit



INSTRUCTIONS FOR COMPLETING THIS FORM

The Americans with Disabilities Act of 1990 (1990) is a civil rights act that requires public transit agencies to provide Paratransit service to people whose disabilities prevent them from using a bus some or all the time. The information you provide will enable us to make an appropriate determination for this applicant. All information will be kept confidential. Thank you for your assistance.

PROVIDERS please note:

Access-a-Ride service is for individuals unable to utilize the fixed route bus and rail system due to:

- a) physical, cognitive or visual impairments that require assistance from another person
- b) impairments related to accessible travel to/from embarking locations

Paratransit service is for individuals who are unable to use fixed route service some or all of the time as a result of their disability. **RTD's bus and rail vehicles are fully accessible.**

Health care providers who can complete this form (must be treating the disability for which applicant is applying for paratransit service):

Physician/PA/NP	RN/ PT / OT/ SLP
Social Worker (MSW)	Psychiatrist/Psychologist
Orientation & Mobility Specialist	Mental Health Clinician
Ophthalmologist/Optomestrist	Respiratory Therapist
Rehabilitation Counselor	

Applicant: Please sign the below Release and provide the form to your health care provider for completion.

Authorization for Release of Information

I hereby authorize the above-named professional to provide information about my disability and abilities to use bus service to the Regional Transportation District (RTD) and/or persons assisting RTD in determining my eligibility for Access-a-Ride service. I understand that this information will be used solely for the purpose of determining my eligibility for Access-a-Ride service and that all medical information about my disability will be kept confidential.

I also understand that, at no expense to me, RTD will require that I participate in an in-person evaluation of my travel skills and agree to such an evaluation.

Signature of **Applicant** or Responsible Party

Date

Professional Medical Verification Form for ADA Paratransit



FORM TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

Applicant name: _____ **D.O.B.:** _____ **Phone number:** _____

Professional name: _____ **Professional phone:** _____

Length of time treating this individual: _____ **Most recent visit:** _____

How does the applicant's disability prevent applicant from performing the following tasks?

*Getting to or from a bus stop: _____

*Navigating the bus system: _____

Impairments are: ☐ Stable ☐ Progressive ☐ Degenerative ☐ Temporary, duration: _____

Does applicant require assistance when traveling outside the home? ☐ Yes ☐ No

Can this applicant travel without supervision? ☐ Yes ☐ No

Does the applicant have the mental capacity, visual and/or hearing ability to:

Ask for, understand and follow directions? ☐ Yes ☐ No

Ask for assistance from appropriate sources? ☐ Yes ☐ No

Judge traffic flow to safely cross a major street? ☐ Yes ☐ No

Safely travel through crowded/complex facilities? ☐ Yes ☐ No

Filter environmental noise? ☐ Yes ☐ No

Locate steps or curb cuts? ☐ Yes ☐ No

Regarding vision impairments only, applicant is impacted by:

☐ N/A ☐ Applicant is blind ☐ Bright unlight ☐ Dimly lit conditions ☐ Night/Darkness

Regarding this applicant's mobility, is applicant able to independently perform the following tasks (using their primary device if indicated):

Travel to and from a vehicle? ☐ Yes ☐ No

Travel up or down hills? ☐ Yes ☐ No

Wait for up to 15 minutes with support? ☐ Yes ☐ No

Travel the following?: **4 blocks:** ☐ Yes ☐ No **3 blocks** ☐ Yes ☐ No

2 blocks ☐ Yes ☐ No **1 block:** ☐ Yes ☐ No

Less than 1 block: ☐ Yes ☐ No

Professional Medical Verification Form for ADA Paratransit



Does weather impact the applicant's ability to travel? ☐ Yes ☐ No

☐ **Wind** **Cold** ☐ <30° ☐ <40° ☐ < 50° **Heat** ☐ >70° ☐ >80° ☐ > 90

Signature of Provider: _____ **License number:** _____

Date: _____

Please return completed form to the applicant, *OR* fax it to 303-299-2169.

****FORMS WITHOUT SIGNATURE AND LICENSE NUMBER WILL DELAY PROCESSING****