



WHAT ADA ELIGIBILITY MEANS FOR PERSONS WITH DISABILITIES IN NAPA COUNTY

As a potential user of VINE Go you have received this packet of materials to explain how the Americans with Disabilities Act (ADA) may affect you. The ADA was created to assure that all persons with disabilities, who cannot use the regular fixed route bus, have complimentary transportation to the bus system. This means that a person who cannot use the regular bus should be able to travel on the same days, during the same hours, and in the same general area as the bus travels, for a fare, which is not more than twice what the bus would charge an adult passenger. The VINE Go Paratransit Service is designed to meet these requirements.

This special type of transportation service is limited to persons who are unable to independently use regular public transit, some or all the time, due to a disability or health related condition. This packet includes registration materials, which ask some questions about your ability to use the regular bus service.

In order to use the VINE Go ADA paratransit service, you must be certified as eligible. Eligibility is determined on a case-by-case basis. According to ADA regulations, eligibility is strictly limited to those who have specific limitations that prevent them from using accessible public transportation.

Your ADA application may be approved for full eligibility (unconditional) or on a limited basis for some trips only (conditional eligibility). If you are determined to be capable of using regular bus and rail transit for all trips, without the help of another person, you will not be eligible for ADA paratransit service.

To apply for eligibility you must fully complete the attached application forms. We will review your ability to use accessible public transportation. We may contact you by phone or consult with your doctor, therapist or other specialist about your condition and abilities.

Eligibility determination will be made within 21 days of when we receive a **complete** application. You will receive notice of your eligibility determination by US Mail. If you are certified as eligible, you may travel throughout the 9 Bay Area counties. If you do not agree with the eligibility determination, you have the right to appeal.

INSTRUCTIONS FOR APPLICATIONS

1. Please PRINT or TYPE full responses to all of the questions. Your detailed responses and explanations will help us make an appropriate determination. Incomplete applications will be returned.

2. You are not required to attach additional pages or information. However, you may want to send other documents that you think will help us understand your limitations. All information that you supply will be kept strictly confidential.
3. You must provide SIGNATURES in two places to complete the application: Applicant Certification (page 8) and Authorization to Release Medical Information (page 9).
4. Send your completed application to Napa County Transportation Planning Agency (NCTPA), 707 Randolph Street, Suite 100, Napa CA 94559.

If you have any questions about this application, or any part of the eligibility process, you may call 707-259-8778 for additional information.

Enclosures

Personal/Contact Information

Name (first, middle, last):

Home Address: _____ Apt. #: _____

City: _____ Zip: _____

Mailing Address (if different from home):

_____ Apt. #: _____

City: _____ Zip: _____

Daytime Phone: (____) _____ TDD/TTY: (____) _____

Evening Phone: (____) _____

Birth Date: ____/____/____ Female Male

Primary Language (please check): English Other (specify) _____

If you need any future written information provided to you in an accessible format, please check which format you prefer:

Diskette Audio tape Braille Large Print
 Other

In case of emergency, whom should we contact?

Name: _____

Relationship: _____

Day Phone: (____) _____ Eve. Phone: (____) _____

Tell Us About Your Disability / Health Related Condition

Please answer the following questions in detail – your specific answers to the questions will help us in determining your eligibility.

1. Which **disability or health related conditions** **PREVENT** you from using regular public transit (i.e. BART, bus, streetcar)?

2. Briefly explain **HOW** your condition prevents you from using regular public transit.

3. When did you first experience the conditions you described above?

0-1 year 1 – 5 years Longer than 5 years

4. Do the conditions you described change from day to day in a way that affects your ability to use public transit?

Yes, good on some days, bad on others. No, doesn't change.
 Don't know.

5. Are the conditions you described:

Permanent Temporary Don't Know

If temporary, how long do you expect this to continue?

6. Do you use any of the following mobility aids or specialized equipment?
(Check all that apply):

<input type="checkbox"/> Cane	<input type="checkbox"/> Power Wheelchair	<input type="checkbox"/> Communication Devices
<input type="checkbox"/> White Cane	<input type="checkbox"/> Service Animal	<input type="checkbox"/> Walker
<input type="checkbox"/> Power Scooter	<input type="checkbox"/> Crutches	<input type="checkbox"/> Manual Wheelchair
<input type="checkbox"/> Leg Braces	<input type="checkbox"/> Portable Oxygen Tank	
<input type="checkbox"/> Other Aid _____		

Tell Us About Your Capabilities and Usual Activities

7. Please check the box that best describes your current living situation:

- 24 hour care
- Board and care
- I receive assistance from someone that comes to my home to help
- I live with family members who help me
- I live independently (without the assistance of another person)

8. How many city blocks can you travel with your usual mobility aid and without the help of another person?

9. Which of the following statements best describes you if you had to wait outside for a ride? (*Check only one response*):

- I could wait by myself for ten to fifteen minutes
- I could wait by myself for ten to fifteen minutes only if I had a seat and shelter
- I would need someone to wait with me

10. Which of the following statements best describes you? (*Check only one response*):

- I have never used regular public transit
- I have used regular public transit but not since the onset of my disability
- I have used regular public transit within the last six months

Tell Us About Your Travel Needs

11. How do you currently travel to your frequent destinations?

(Check all that apply):

- Buses Paratransit Drive myself BART
 Taxi Ferry Streetcar Someone drives me
 Other _____

12. Do you travel with the assistance of another person?

- Always Sometimes Never

13. If you travel with the assistance of another person always or sometimes, what type of assistance do they provide?

14. Are you able to get to and from the public transit stop nearest your home?

- Yes No Sometimes

If no or sometimes, explain why:

15. Are you able to grasp handles or railings, coins or tickets while boarding or exiting a transit vehicle?

- Yes No Sometimes Don't know, never tried it

If no or sometimes, explain why:

16. Are you able to maintain balance and tolerate movement of a public transit vehicle when seated?

- Yes No Sometimes Don't know, never tried it

If no or sometimes, explain why:

17. Are you able to get on or off a public transit bus if it has either a lift or a kneeler that lowers the front of the bus?

Yes No Sometimes Don't know, never tried it

If no or sometimes, explain why:

18. Please add any other information that you would like us to know about your abilities.

Have you answered all the questions and provided explanations where required?

INCOMPLETE APPLICATIONS WILL BE RETURNED.

Applicant Certification

I **certify** that the information in this application is **true** and **correct**. I understand that knowingly falsifying the information will result in denial of service. I understand all information will be kept confidential, and only the information required to provide the services I request will be disclosed to those who perform the services.

I understand that it may be necessary to contact a professional familiar with my functional abilities to use public transit in order to assist in the determination of eligibility.

Sign here:

Applicant's signature _____ Date

Did someone help you in filling out this form? Yes No

If yes, Name: _____ Phone: (____) _____

Relationship: _____

Authorization to Release Medical Information

(to be completed by applicant)

I **hereby authorize** the following licensed professional (doctor, therapist, social worker, etc.) who can verify my disability or health related condition, to release this information to my local public transit agency. This information will be used only to verify my eligibility for paratransit services. I understand that I have the right to receive a copy of this authorization, and that I may revoke it at any time.

Name of Professional who may release my medical information:

Address:

Medical Record or ID #, if known:

Sign here:

Applicant's signature _____ Date



**ADA MEDICAL
VERIFICATION FORM**

has applied for the VINE Go Paratransit service. Please complete and return this form to *help us in determining* paratransit eligibility for the person named above. The public transit property in Napa Valley provides paratransit services for persons who have a disability that prevents use of existing public transit. The key phrase is “THE DISABILITY PREVENTS...” and not the “the disability makes it difficult ...” to use public transit. It is imperative that services be utilized only by those individuals that cannot access public transit services (buses, BART, light rail, streetcars, etc.). Please note that having a disability alone is not a qualifying factor. An applicant’s disability must prevent use of a public transit system.

To be qualified for ADA paratransit services, the applicant’s disability must prevent her/him from independently using accessible public transit (for example, travel to a bus stop, waiting at a bus stop, identifying the correct transit vehicle, boarding or disembarking a vehicle, navigating the system, etc.).

Please explain how this applicant’s condition(s) affects her/his ability to use public transit:

Applicant’s condition(s) is (*please check one*): PERMANENT TEMPORARY
If Temporary, I expect applicant’s condition(s) will continue for _____ months.

Name: _____

Professional Title: _____

Medical License Number: _____ Day Phone: _____

Address, City, Zip: _____

Signature: _____ Date: _____

**TO BE COMPLETED BY A MEDICALLY LICENSED PROFESSIONAL ONLY
PLEASE TYPE OR PRINT**