Park City Mobility
Application for ADA Paratransit Service

Park City Transit ADA Paratransit Service is provided in accordance with the Americans with Disabilities Act of 1990. Park City Mobility Paratransit Service is for persons with physical, cognitive, mental, visual, or other disabilities which functionally prevent them from using the Park City / Summit County fixed-route bus system permanently, temporarily, or conditionally.

Disability alone does not guarantee eligibility for paratransit service. The decision is based solely on the applicant's functional ability to use Park City / Summit County Transit buses. The PCT bus system is fully accessible, with wheelchair accessible buses and major transfer facilities. The unavailability of fixed-route service, difficulties using fixed route or long travel times does not constitute eligibility for Park City Mobility. Age, distance from a bus stop, or inability to drive are not taken into consideration when making a determination of eligibility.

All applicants seeking certification for ADA Paratransit Service are required to undergo an eligibility determination process. This includes, but is not limited to, a review of the applicant's own assessment of their ability to use fixed-route bus service, a medical verification of the disability, and may also include a functional assessment or in person interview.

The applicant (or a person assisting the applicant) must complete this application in full. A licensed medical professional must complete Section 6 (Pages 10 - 13). Incomplete applications will be returned. If a completed application form is not received within 30 days it may be declared abandoned and purged from our records. Processing of applications may take up to 21 calendar days.

The information you provide in this application is confidential and will only be shared with persons involved in determining eligibility and facilitating transportation, and as required by law.

FOR OFFICE USE ONLY - DO NOT WRITE IN THIS SPACE		
Date Received:	File ID#	Approval:
Processor:		Expiration:
Signature:		Date:

Section 1 – Information About the Applicant

1. General Information

Applicant's Name:

Street Address:

Apt / Unit #: City:

State: Zip:

Home Phone: Cell:

Work: Other:

Date of Birth: Email Address:

Mailing Address (If different than above):

Apt / Unit #: City:

State: Zip:

2. Emergency Contact Information

Name:

Home Phone: Cell:

Work: Other:

Relationship To Applicant:

3. Correspondence Preference

Do you prefer materials in any of the following formats?

☐ Large Print ☐ Braille ☐ Audio CD

☐ Other:

Section 2 – Information About the Applicant's Disability

1. What type or types of disabilities prevent you from using Park City / Summit County regular fixed route transit buses? (Check all that apply)

☐ Developmental / Cognitive Disability ☐ Visual Impairment / Blindness

☐ Physical Disability ☐ Mental Illness

☐ Other: _____

2. Please describe your disability in detail, including how it prevents you from using fixed route services:

3. Is the disability described above temporary or permanent?

☐ Temporary – If so what is the expected duration? _____

☐ Permanent ☐ I don't know

4. Do you use any of the following mobility aids or devices? (Mark all that apply)

☐ Cane ☐ Walker ☐ Crutches

☐ Portable Oxygen ☐ Powered Scooter ☐ Powered Wheelchair

☐ Manual Wheelchair ☐ Service Animal (Type): _____

☐ Other: _____

Note: We may not be able to accommodate your wheelchair / scooter if it exceeds 48 inches in length, 30 inches in width, or if the combined weight of the rider and mobility aid is more than 600 pounds. Operators are not permitted to assist riders in connecting or disconnecting oxygen or other breathing aids. Service animals may not occupy a seat and must be under the direct control of the rider at all times.

5. Do you require the assistance of a Personal Care Attendant (PCA) or someone who must assist you with daily life functions?

☐ Yes ☐ No

Please note - Park City Mobility does not provide PCA's and cannot assist you with functions such as taking medication, connecting / disconnecting medical equipment, eating, mobility beyond getting to / from the vehicle, personal hygiene, etc. Park City Mobility staff are not authorized to enter any residence or building in order to provide assistance to you. If you require assistance with these types of activities, we strongly suggest that a PCA accompany you.

6. On your own or using an assistive device, how far can you travel?

☐ I can get to the curb in front of my home.

☐ Up to 3 blocks (1/4 mile) ☐ Up to 6 blocks (1/2 mile)

☐ Up to 9 blocks (3/4 mile) or more ☐ Cannot travel outside of home (explain):

7. Are you able wait at a stop / pickup location for up to 15 minutes?

☐ Yes ☐ Only if there is a bench or shelter

☐ No – explain: _____

8. Are you able to climb four 8-inch steps?

☐ Yes ☐ No, I must use a wheelchair lift or ramp

9. Do you currently use regular fixed-route transit bus service for transportation?

☐ Yes ☐ No ☐ Sometimes

If you answered "yes" or "sometimes" to the previous question, please indicate what best describes how you use public transportation by checking all that apply:

- ☐ Travel to and from one destination only.
- ☐ Travel to and from a few destinations.
- ☐ Travel to and from many destinations.
- ☐ Travel only to locations I am familiar with.
- ☐ Someone must accompany or assist me.
- ☐ Only if the weather is not too hot or cold.

10. Please list the destination(s), if any, that you currently use regular fixed-route bus service to access:

11. Please check one answer to each question below according to how it relates to your ability to travel within the community and utilize Park City / Summit County transit buses.

	Yes	Sometimes	No
A. Are you able to tolerate very hot or very cold weather?	☐	☐	☐
B. Are you able to recognize destinations, landmarks and bus stops?	☐	☐	☐
C. Are you able to recognize, read, and understand printed information?	☐	☐	☐
D. Are you able to communicate your needs to another person?	☐	☐	☐
E. Are you able to follow directions?	☐	☐	☐
F. Are you able to hear and process spoken words or auditory information?	☐	☐	☐

	Yes	Sometimes	No
G. Are you able to deal with unexpected situations or changes in routine (such as bus detours)?	☐	☐	☐
H. Are you able to recognize curbs and other drop offs?	☐	☐	☐
I. Are you able to independently travel along sidewalks or other pedestrian ways?	☐	☐	☐
J. Are you able to cross streets independently?	☐	☐	☐
K. Are you able to identify the correct bus and / or bus stop?	☐	☐	☐
L. Are you familiar with what to do if you miss your bus?	☐	☐	☐

If you answered any of the above questions with "Sometimes" or "No" please explain why below:

12. Are there any other conditions which limit your ability to use Park City / Summit County buses?

Section 3 – Authorization to Release Information

The following licensed physician or other healthcare provider is familiar with my disability and is hereby authorized to release to Park City Mobility specific information about my disability as requested. I understand that this information may be necessary in order to evaluate my request for paratransit eligibility and that any information released will be used solely for this purpose.

Name of Professional: Title:

Address:

City: State: Zip:

Phone Number:

Applicant's Signature: Date:

Legal Guardian's signature required if applicant is not his / her own guardian or under age 18.

Guardian's Signature: Date:

Print Name:

Section 4 – Applicant's Certification

Please read and check the box next to each of the following statements, indicating that you have read and understand them.

- ☐ Park City Mobility is public transportation and I will be sharing rides with others.
- ☐ Park City Mobility does not provide emergency services.
- ☐ Park City Mobility may arrive up to 30 minutes after the scheduled pickup time and be considered on time. I will be ready and waiting for my ride at the scheduled pickup time.
- ☐ Park City Mobility will only wait 5 minutes for me to board once the vehicle has arrived to pick me up.
- ☐ I have received a copy of Park City Mobility's ADA Policy & Complementary Paratransit Plan and I understand that it is my responsibility to read, understand and comply with these policies at all times.

I certify that all information contained in this application is true and accurate. I understand that misinformation or misrepresentation of facts will be cause for disqualification or rejection of my ADA eligibility.

Applicant's Signature: _____ Date: _____

Legal Guardian's signature required if applicant is not his / her own guardian or under age 18.

Guardian's Signature: _____ Date: _____

Print Name: _____

If someone other than the applicant or the applicant's legal guardian is preparing this form, please provide the following information regarding the preparer:

Preparer's Signature: _____ Date: _____

Print Name: _____

Section 5 – Guardian Authorization

The following individual is hereby designated as my legal guardian for the purpose of paratransit transportation and is authorized to contact and coordinate with Park City Mobility on my behalf. This may include, but is not limited to, scheduling rides, cancelling rides, making decisions regarding the service I receive, and accepting communications from Park City Mobility in the course of providing service to me. I understand that I may be held accountable for the decisions and actions of this person, pursuant to the policies contained in the Park City Transit Department ADA Policy & Complementary Plan, including the loss of eligibility for noncompliance with these policies.

Primary Parent / Guardian

Print Name: Date:

Signature:

Secondary Parent / Guardian

Print Name: Date:

Signature:

Please note: If your disability does not prevent you from communicating with Park City Mobility and/or you do not specify a legal guardian, we will only accept ride requests, cancellations or other communications regarding the service you receive from you, the applicant. Furthermore, Park City Mobility will not release any information regarding the service you receive, including scheduled rides, to anyone but you or your designated legal guardian.

STOP!

This concludes the portion of the application to be completed by the applicant. The remaining pages are to be completed **only** by the licensed medical professional identified in Section 3 (page 7). Once Section 6 has been completed by the medical professional:

Mail the completed application to:

Park City Mobility
P.O. Box 1480
Park City, UT, 84060

Or deliver in person to:

Park City Public Works
1053 Ironhorse Drive
Park City, UT, 84060

If you have questions regarding this application, our policies and procedures, or require assistance in completing your application, please contact us at:

Mobility Dispatcher: (435)615-5353
Mobility Supervisor: (435)615-5356
TTY Phone: (435)615-7041
Email: pcmobility@parkcity.org

Section 6 – Physician Verification

Dear Health Care Professional,

You are being asked to provide information regarding this applicant's disability. Federal Law is very specific about ADA Paratransit eligibility criteria. The law restricts eligibility to individuals who:

- as a result of their disability, cannot board, ride, or disembark from a regular fixed route bus or
- have a specific impairment-related condition which prevents them from getting to or from a bus stop or
- need a wheelchair lift when a wheelchair lift-equipped bus is not available on the route that they need to travel.

PLEASE NOTE: This **does not** include individuals who find it **difficult** or **uncomfortable** to get to and from bus stops. In providing information you should consider only the presence of a disability or health condition and not the applicant's age or economic status.

This form must be completed in its entirety; any questions left blank will deem this form void and incomplete. Please write clearly and legibly, and do not use diagnostic codes. Once completed, please return to the applicant.

1. **Please describe the diagnosed disability you are currently treating this individual for:**

2. **Please describe *in detail* how this disability prevents the applicant from using regular fixed-route transit bus services.**

3. Is the disability described permanent or temporary?

☐ Temporary – If so what is the expected duration? _____

☐ Permanent

Date of onset: Date of last visit:

4. Does the applicant use any of the following mobility aids or devices?

☐ Cane ☐ Walker ☐ Crutches

☐ Portable Oxygen ☐ Powered Scooter ☐ Powered Wheelchair

☐ Manual Wheelchair ☐ Service Animal (Type): _____

☐ Other:

5. Does the applicant require the assistance of a Personal Care Attendant (PCA)?

☐ Yes ☐ No

6. On their own or using an assistive device, how far can the applicant travel?

☐ Less than 200 feet

☐ Up to 3 blocks (1/4 mile) ☐ Up to 6 blocks (1/2 mile)

☐ Up to 9 blocks (3/4 mile) or more ☐ Cannot travel outside of home (explain):

7. Is the applicant able to wait at a stop / pickup location for up to 15 minutes?

☐ Yes ☐ Only if there is a bench or shelter

☐ No – explain: _____

8. Is the applicant able to climb four 8-inch steps?

☐ Yes ☐ No, must use a wheelchair lift or ramp

9. Please check one answer to each question below according to how it relates to the applicant's ability to travel within the community and utilize Park City / Summit County transit buses.

	Yes	Sometimes	No
A. Is the applicant able to tolerate very hot or very cold weather?	☐	☐	☐
B. Is the applicant able to recognize destinations, landmarks and bus stops?	☐	☐	☐
C. Is the applicant able to recognize, read, and understand printed information?	☐	☐	☐
D. Is the applicant able to communicate his / her needs to another person?	☐	☐	☐
E. Is the applicant able to follow directions?	☐	☐	☐
F. Is the applicant able to hear and process spoken words or auditory information?	☐	☐	☐
G. Is the applicant able to deal with unexpected situations or changes in routine (such as bus detours)?	☐	☐	☐
H. Is the applicant able to recognize curbs and other drop offs?	☐	☐	☐
I. Is the applicant able to independently travel along sidewalks or other pedestrian ways?	☐	☐	☐
J. Is the applicant able to cross streets independently?	☐	☐	☐
K. Is the applicant able to identify the correct bus and / or bus stop?	☐	☐	☐
L. Is the applicant able to determine what to do if he / she misses the bus?	☐	☐	☐

If you answered any of the previous questions with “Sometimes” or “No” please explain why below:

I certify that the medical information provided in this application is true and accurate to the best of my knowledge and is consistent with the applicant's medical diagnosis.

Physician Signature: Date:

Physician Printed Name: Title:

Address:

City: State: Zip:

Phone Number: