Internal Use Only: Date Received: _____ Date Verified Complete: _____
___: Full ___: Temp ___: Cond ___: Not Eli Expires (3 years): _____

Gallop

Combined ADA Paratransit Eligibility & Recertification Application
Includes Required Health Care Provider Verification Form

101 11th Avenue, Greeley, CO 80631
VIA Phone: (970) 350-9290 | Fax: (970) 350-9285

APPLICATION FOR ADA PARATRANSIT SERVICE

Thank you for your interest in Gallop's ADA Paratransit Service provided by VIA. ADA Paratransit Service is provided in accordance with the Americans with Disabilities Act of 1990. This service is intended for individuals with physical, cognitive, mental, visual, or other disabilities that **functionally prevent** them from independently using fixed-route bus system **permanently, temporarily, or conditionally**. Applicants will be notified of the determination by mail.

Important Notes About Eligibility

- Disability alone does **not** guarantee eligibility.
- Eligibility is based on your **functional ability** to use fixed-route bus service.
- All GET buses and major facilities are fully accessible (ramps/lifts, priority seating, etc.).
- The following **do not** qualify someone for ADA Paratransit Service:
    - Age
    - Inability to drive
    - Distance to bus stops
    - Weather sensitivity
    - Lack of bus service near your home
    - Medicare/Medicaid qualification
    - Trip duration or convenience

- Eligibility may require:
    - Applicant self-assessment
    - Professional medical verification
    - Functional assessment
    - In-person interview

All information is confidential and shared only for eligibility determination, transportation facilitation, or as required by law.

Both the Applicant Form and the Professional Verification Form must be submitted to determine eligibility. The 21-calendar-day determination period begins once both forms are received and the application is complete. If required information is missing, we will notify the applicant and provide an opportunity to submit the necessary information. If the requested information is not received within thirty (30) calendar days of the notification, the application may be closed.

If you need assistance completing the form, contact (970) 350-9290

Continue on next page...

SECTION 1 – APPLICANT INFORMATION

Please Type or Print Clearly

1. ○ Mr. ○ Miss ○ Mrs. ○ Ms. ○ Dr. ○ Other: _____
   Full Name:
   Date of Birth:
   Address:
   City, State, Zip:
   Home Phone:
   Cell Phone:
   Work Phone:
   Email:
2. Preferred Method of Communication (select one):
   ○ Home Phone ○ Cell Phone ○ Work Phone ○ Email

Continue on next page...

SECTION 2 – MOBILITY INFORMATION

3. **Mobility aids used (check all that apply):**
   - ☐ Cane
   - ☐ Walker
   - ☐ Crutches
   - ☐ Portable Oxygen (larger than a shoulder bag)
   - ☐ Powered Scooter
   - ☐ Powered Wheelchair
   - ☐ Manual Wheelchair
4. **If wheelchair/scooter, please complete:**
   Length: _____ Width: _____ Weight with rider: _____
5. ☐ Service Animal — Type: _____
   ☐ Other mobility device: _____

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6. Do you require a Personal Care Attendant (PCA)?
   ☐ Yes ☐ No

(PCA note retained: GET does not provide PCAs…)

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7. **How far can you travel on your own or with mobility devices?**
   - ☐ To the curb only
   - ☐ ¼ mile (3 blocks)
   - ☐ ½ mile (6 blocks)
   - ☐ ¾ mile (9 blocks)
   - ☐ More than ¾ mile
   - ☐ Cannot travel outside home (explain): _____

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8. Are you able to climb three 12-inch steps using handrails?
   ☐ Yes ☐ No, I must use a lift or ramp.

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9. **Are you able to wait outside for 10 minutes?**
   - ☐ Yes
   - ☐ Yes, if sheltered or seated
   - ☐ Sometimes:

   When? _____ Why? _____
   - ☐ No

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10. **Do you currently use GET fixed-route bus service?**

    ☐ Yes ☐ No ☐ Sometimes:

    When? _____ Why? _____
11. If yes/sometimes, select all that apply:
    - ☐ To/from one destination
    - ☐ To/from few destinations
    - ☐ Many destinations
    - ☐ Only familiar locations
    - ☐ Only with assistance
    - ☐ Weather dependent

Continue on next page...

SECTION 3 – FUNCTIONAL ABILITY

Check the answer that best applies to your ability:

A. Tolerate very hot/cold weather?
☐ Yes ☐ No ☐ Sometimes:
When? _____ Why? _____

B. Recognize destinations/landmarks/stops?
☐ Yes ☐ No ☐ Sometimes:
When? _____ Why? _____

C. Read/understand printed information?
☐ Yes ☐ No ☐ Sometimes:
When? _____ Why? _____

D. Communicate needs to others?
☐ Yes ☐ No ☐ Sometimes:
When? _____ Why? _____

E. Follow directions?
☐ Yes ☐ No ☐ Sometimes:
When? _____ Why? _____

F. Hear and process spoken information?
☐ Yes ☐ No ☐ Sometimes:
When? _____ Why? _____

G. Handle changes in routine (detours, delays)?
☐ Yes ☐ No ☐ Sometimes:
When? _____ Why? _____

H. Recognize drop-offs/curbs?
☐ Yes ☐ No ☐ Sometimes:
When? _____ Why? _____

I. Travel independently on sidewalks/paths?

☐ Yes ☐ No ☐ Sometimes:

When? _____ Why? _____

J. Cross streets independently?

☐ Yes ☐ No ☐ Sometimes:

When? _____ Why? _____

K. Identify the correct bus/stop?

☐ Yes ☐ No ☐ Sometimes:

When? _____ Why? _____

L. Know what to do if you miss your bus?

☐ Yes ☐ No ☐ Sometimes:

When? _____ Why? _____

12. Other functional limitations that prevent you from independently using the GET fixed route buses:

13. Additional relevant information:

Continue on next page...

SECTION 4 – APPLICANT CERTIFICATIONS

Please review the following statement before signing:

☐ GET is shared-ride public transportation.
☐ GET does not provide emergency medical transport.
☐ Trip times may be negotiated up to 1 hour earlier/later.
☐ A bus is considered on time if it arrives within +20 minutes of pickup time.
☐ Drivers wait only 5 minutes after arrival.
☐ I have received GET Paratransit information/pamphlet.

I certify the information provided is accurate. Misrepresentation may result in denial or loss of eligibility.

Applicant Signature: _____ Date: _____
Guardian (if under 18): _____ Date: _____
Witness: _____ Date: _____

Continue on next page...

SECTION 5 – ASSISTANT INFORMATION

(If someone completed this application on behalf of the applicant)

Name: _____
Address: _____
City/State/Zip: _____
Phone: _____
Signature: _____ Date: _____

SECTION 6 – EMERGENCY CONTACTS

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

SECTION 7 – AUTHORIZED PERSONS FOR SERVICE COMMUNICATIONS

☐ Applicant

☐ Person assisting with the application

☐ Emergency contacts listed above

☐ Other (provide):

Name: _____ Phone: _____
Name: _____ Phone: _____

Continue on next page...

SECTION 8 – AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(TO BE COMPLETED BY THE 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 Greeley Evans Transit eligibility certification staff or a contractor working for the agency to conduct eligibility screenings. This information will be used only to verify my eligibility for ADA paratransit services. I understand that I have the right to request and receive a copy of this authorization, and that I may revoke it at any time.

Name of Medical Professional who may release my medical information:

Name of Medical Professional: _____

Address of Medical Professional: _____

City, State and Zip Code: _____

Telephone Number of Medical Professional: _____

Fax Number of Medical Professional: _____

Medical Record or Identification number, if known: _____

Applicant Name (Please Print) _____

Applicants Signature: _____ Date: _____

Please return this form and the following completed form to:

Email to: applypara-grl@ridewithvia.com

Mail or bring to: Gallop, 101 11th Avenue, Greeley, CO 80631

HEALTH CARE PROVIDER VERIFICATION FORM

(Must be completed and signed by a licensed professional)

Dear Provider,
Your patient is applying for ADA Paratransit Service. Please complete only the sections that apply. The information is confidential and used solely for eligibility determination.

Applicant Name: _____
Address: _____

SECTION A – GENERAL QUESTIONS (Must be completed by all providers)

1. **Date of Birth:** _____
2. **Your professional relationship to applicant:** _____
   a. How long have you known the applicant? _____
   b. Date of last face-to-face contact: _____
3. **Does the applicant have a disability?**
   ☐ Yes ☐ No
   If yes, describe how it limits daily activities:

4. **Date of onset:** _____
5. **Is the disability permanent?**
   ☐ Yes ☐ No → Expected recovery date: _____

Continue on next page...

SECTION B – PHYSICAL DISABILITIES *(Complete if applicable)*

Diagnosis/Prognosis:

1. How does the condition prevent independent use of fixed-route bus service?

2. Is a PCA required? ☐ Yes ☐ No

3. Skills assessment (check ability with assistive devices if applicable):
   - Travel distance:
     ☐ <200 ft ☐ ¼ mile ☐ ½ mile ☐ ¾ mile ☐ >¾ mile
   - Cross streets safely: ☐ Yes ☐ No ☐ Sometimes:
     When? _____ Why? _____
   - Navigate slopes/terrain: ☐ Yes ☐ No ☐ Sometimes:
     When? _____ Why? _____
   - Travel in snow/ice: ☐ Yes ☐ No ☐ Sometimes:
     When? _____ Why? _____
   - Manage hot/cold weather: ☐ Yes ☐ No ☐ Sometimes:
     When? _____ Why? _____
   - Transfer between buses: ☐ Yes ☐ No
   - Wait without bench: ☐ Yes ☐ No ☐ Sometimes:
     When? _____ Why? _____
   - Use lift/ramp: ☐ Yes ☐ No
   - Reach seat/securement: ☐ Yes ☐ No
   - Stand on moving bus: ☐ Yes ☐ No
   - Medications affecting travel? ☐ Yes ☐ No

Continue on next page...

SECTION C – COGNITIVE IMPAIRMENTS *(If applicable)*

Diagnosis/Description: _____
Prognosis: _____
Classification: ☐ Mild ☐ Moderate ☐ Severe ☐ Profound

Behavioral concerns? ☐ Yes ☐ No
If yes, describe: _____

Skills:

• Tell time	☐ Yes	☐ No
• Follow directions	☐ Yes	☐ No
• Follow schedules	☐ Yes	☐ No
• Know when lost & seek help	☐ Yes	☐ No
• Cross streets	☐ Yes	☐ No
• Communicate needs	☐ Yes	☐ No
• Avoid dangers	☐ Yes	☐ No
• Transfer buses	☐ Yes	☐ No
• Would travel training help?	☐ Yes	☐ No

SECTION D – PSYCHIATRIC DISABILITIES

Diagnosis: _____
Medications? ☐ Yes ☐ No
Able to travel alone consistently? ☐ Yes ☐ No

Describe limitations in:

- Following directions
- Finding bus stops
- Crossing streets
- Waiting for bus
- Boarding correct bus
- Transferring
- Exiting correctly
- Overall safe travel

(Write in space or attach note.)

SECTION E – SEIZURE DISORDERS

Type: _____
Frequency: _____
Prognosis: _____
Aura present? ☐ Yes ☐ No
Can travel alone? ☐ Yes ☐ No
Medication effects: ☐ Yes ☐ No
Explain: _____
Expected duration: _____

SECTION F – VISUAL IMPAIRMENTS

Diagnosis: _____
Legally blind? ☐ Yes ☐ No
Onset: _____ Prognosis: _____
Visual acuity/fields (L/R/Both): _____

Mobility Skills (O&M Specialist if applicable):

- Travel alone? ☐ Yes ☐ No
- Cross streets? ☐ Yes ☐ No
- Recognize curbs/steps? ☐ Yes ☐ No
- Travel to familiar locations? ☐ Yes ☐ No
- Travel to unfamiliar locations? ☐ Yes ☐ No
  Environmental factors affecting travel:

Continue on next page...

HEALTH CARE PROVIDER SIGNATURE

I certify the above information is accurate to the best of my knowledge.

Provider Name:
Professional License, Registration certification #:
Expires:
Agency:
Address:
Phone:
Signature:
Date:

Please return completed verification:

☐ To the patient **OR**

☐ Email to applypara-grl@ridewithvia.com

☐ Mail or bring to Gallop, 101 11th Avenue, Greeley, CO 80631

☐ Fax (970) 350-9285