



DEMAND RESPONSE ELIGIBILITY APPLICATION

Demand Response Service, the Redding Area Bus Authority (RABA) Americans with Disabilities Act (ADA) paratransit service, is an origin-to-destination, shared ride, advanced reservation service for persons with disabilities who are functionally unable to use Fixed Route Bus Service. This application allows you to detail how your disability prevents you from riding the RABA Fixed Route Bus System. Eligibility for Demand Response Service is not granted because you find it difficult or uncomfortable to get to/from bus stops or to ride the bus. Likewise, age and disability do not confer eligibility. You must be functionally unable to utilize the Fixed Route Bus System.

There are two parts to this application: *Demand Response Applicant Form* (green) and *Demand Response Physician Verification Form* (yellow).

Here is what you need to do:

1. Complete the *Demand Response Applicant Form* (green) and return it to RABA. Remember to sign and date Page 5. Also, complete the *Certification Form for Personal Care Attendant* on Page 6, indicating whether or not you need a personal care attendant.
2. Complete the *Authorization Form for Disclosure of Protected Health Information*, which is part of the *Demand Response Physician Verification Form* (yellow). You must either authorize or refuse to authorize disclosure of your information.
 - If you authorize, specify in and sign the authorization form. Then, take the completed/signed authorization form and the remainder of the *Demand Response Physician Verification Form* to a physician that is familiar with the functional abilities associated with your disability. Tell the physician's office/staff that the verification form **MUST BE SIGNED BY A LICENSED MEDICAL CARE PROVIDER, specifically, a Medical Doctor (MD), Physician Assistant (PA), or Family Nurse Practitioner (FNP)**. The physician's office will return the completed/signed *Demand Response Physician Verification Form* to RABA.
 - If you refuse to authorize, specify in the authorization form. Return the authorization form to RABA. The remainder of the *Demand Response Physician Verification Form* does not need to be completed/returned to RABA.

The review process will not begin until both parts of your application (green and yellow) are received. During the review process, you can use Demand Response Service and you may be required to participate in an in-person interview. Your application will be reviewed/processed within 21 days. Shortly thereafter, you will receive an ADA paratransit eligibility determination letter. Unless you are determined not eligible, Demand Response Service will continue uninterrupted.

There is no cost to apply for Demand Response Service. To use Demand Response Service, the one-way cost is \$3.00, plus \$1.50 for each additional zone. Demand Response Service hours are Monday to Friday, from 6:20 a.m. to 7:30 p.m., and Saturday, from 9:20 a.m. to 7:30 p.m.

RETURN YOUR APPLICATION TO RABA

By mail or in person:
RABA Office
3333 S. Market Street
Redding, CA 96001

By fax:
(530) 241-4667



DEMAND RESPONSE APPLICANT FORM

Personal / Contact Information

Name: _____
Last First Middle

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

Date of Birth ____/____/____ Female Male

Primary Language English Other (specify) _____

Home Address _____
Street Apt. #

City _____ State _____ Zip Code _____

Mailing Address (if different) _____
Street Apt. #

City _____ State _____ Zip Code _____

Do you manage your own affairs and deal with your own mail? Yes No
If no, to whom should important correspondence be mailed?

Name _____ Relationship _____

Address _____ City _____

Zip Code _____ Phone (_____) _____

Emergency Contact

Name _____ Relationship _____

Daytime Phone (_____) _____ Evening Phone (_____) _____

For RABA Use Only:

Approved Denied Initials: _____ Date: _____

PCA: Yes No Sometimes Client ID # _____

Expiration Date: _____

Tell Us About Your Disability

Please answer the questions in detail. Your answers will help us determine your eligibility.

1. What is your disability?
 - Intellectual, cognitive, or vision disability
 - Other impairment disability: _____
Impairment disability includes any loss or abnormality of psychological (mind), physiological (organ/cell/tissue/system), or anatomical (body) structure or function.
 - Not disabled

2. How does your disability functionally prevent you from using Fixed Route Bus Service?

3. Do the functional conditions described change from day to day, allowing you to use Fixed Route Bus Service?
 - Yes, they change. I can use Fixed Route Bus Service on some days, but not on other days.
 - No, they do not change.
 - Don't know.

4. Are the functional conditions described:
 - Permanent Temporary Don't Know

If temporary, how long do you expect the functional conditions to continue?

Tell Us About Your Mobility and Bus Capabilities

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

<input type="checkbox"/> None	<input type="checkbox"/> Power Wheelchair	<input type="checkbox"/> Communication Devices
<input type="checkbox"/> Cane	<input type="checkbox"/> Service Animal	<input type="checkbox"/> Walker
<input type="checkbox"/> White Cane	<input type="checkbox"/> Crutches	<input type="checkbox"/> Manual Wheelchair
<input type="checkbox"/> Power Scooter	<input type="checkbox"/> Portable Oxygen Tank	<input type="checkbox"/> Leg Braces
<input type="checkbox"/> Other Aid		

6. If you use a manual or electric wheelchair or scooter, size and weight restrictions apply.

What are the dimensions of your mobility aid?	Width _____	Length _____
What is the weight of your mobility aid (unoccupied)?	Pounds _____	
What is your weight?	Pounds _____	

7. Please check the box that best describes your current living situation.
- Live independently (without the assistance of another person)
 - 24-hour care or skilled nursing facility
 - Live with family members who help me
 - Assisted living facility
 - Receive assistance with daily living activities from someone that comes to my home
8. How far can you walk or travel using the mobility aids or specialized equipment identified in Question 5 above without the help of another person?
- Less than 1 block
 - Up to 2 blocks
 - 3 to 6 blocks
 - 7 or more blocks
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 10 to 15 minutes.
 - I could wait by myself for 10 to 15 minutes only if I had a seat and shelter.
 - I would need someone to wait with me because:
-

10. Which of the following statements best describes you?
(Check only one response)
- I have never used RABA Fixed Route Bus Service.
 - I have used RABA Fixed Route Bus Service within the last 6 months.
 - I have used RABA Fixed Route Bus Service but not since the onset of my disability.
 - I have tried to use RABA Fixed Route Bus Service but was unable because:
-

11. Can you get to and from the bus stop nearest your house by yourself?

Yes No Sometimes Don't know

If no or sometimes, check why:

Hills Curbs Weather No sidewalk
 Distance to the bus stop Street crossings No bench/shelter

12. Can you grasp handles, railings, coins, and tickets?

Yes No Sometimes Don't know

If no or sometimes, explain why.

Tell Us About Your Travel Needs

13. Do you have a current Driver's License? Yes No

14. How do you currently travel? *(Check all that apply)*

Bus. How many times per month? _____

Special Service/Program *(Circle what you use)*. How many times per month? _____

RABA Demand Response, Far Northern Regional Center, Dignity Health Connected Living, Medical Transportation

Taxi or Uber/Lyft. How many times per month? _____

I drive myself. How many times per month? _____

Family or friends drive me. How many times per month? _____

15. Please provide the address of the places you travel to most often (e.g., doctors, physical therapist, work, stores, restaurants, friends, relatives).

Place	Address

16. Please add any other information that you would like us to know about your disability, mobility, or needs.

Applicant's Certification

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

I understand that it may be necessary to contact a physician who is familiar with the functional abilities associated with my disability to assist in the determination of eligibility.

I understand that RABA Demand Response Service is an origin-to-destination service, with limited driver assistance. Drivers will help me into the vehicle, but I must be able to travel to the vehicle under my own power. Drivers cannot enter my residence and cannot help me with medication, food/drink, money, or cargo.

I understand that I must complete the *Certification for Personal Care Attendant* on the next page if I require the assistance of a personal care attendant.

I understand that it is my responsibility to notify RABA if my condition changes. If my condition improves after I have been determined eligible, I may be asked to reapply. I understand that periodically, I may need to complete a recertification to remain eligible for RABA Demand Response Service.

Signature

Date

Did someone help you in filling out this form?

Yes

No

Can we contact this person for additional information?

Yes

No

Name _____

Phone (_____) _____

Relationship _____

Certification Form for Personal Care Attendant

A personal care attendant (PCA) is someone whose help you require for daily life activities (e.g., eating, dressing, personal hygiene, carrying packages, finding your way). A PCA does not have to be the same person.

Do you require the assistance of a PCA?

No

Yes

Sometimes

If yes or sometimes, please complete the information below and sign.

Explain how your PCA helps you:

I certify that, due to my disability, I require the services of a PCA to assist me on a regular basis and travel with me on RABA Demand Response Service.

I understand that RABA reserves the right to contact my physician to verify my need for a PCA.

I understand that fraudulently claiming to travel with a PCA to avoid paying a fare for a companion may result in suspension or termination of service.

Signature _____

Date _____

Authorization Form for Disclosure of Protected Health Information

I, _____, understand that I do not have to sign this
(Printed Applicant Name)

authorization in order to be considered for Demand Response Service, but I understand that no weight will be given to health or medical conditions claimed which cannot be verified. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Check one:

- I refuse to authorize. As part of my application, I will check this box and return this form to RABA. The remainder of the *Demand Response Physician Verification Form* will not be completed/returned.
- I will authorize. (*Complete below*) As part of my application, I will check this box and provide this form to my physician, who will complete the remainder of the *Demand Response Physician Verification Form*. My physician will return the complete *Demand Response Physician Verification Form* to RABA.

I authorize _____, who is completing the
(Printed Physician Name)

Demand Response Physician Verification Form on my behalf, to release information about my disability and functional abilities, as well as any supporting or other pertinent information about my health or medical condition, to the Redding Area Bus Authority (RABA) for review. RABA will use this information to determine eligibility for Demand Response Service, the RABA Americans with Disabilities Act (ADA) paratransit service. I understand that all medical information about my disability will be kept strictly confidential.

Signature of Applicant or Legal Guardian

Date

NOTE: Form may be signed by a legal guardian with the power of attorney only if documentation showing legal authority to act and sign on applicant's behalf is also provided. Applicant must be provided a copy of the form.)

Attention Physician: Please return a copy of this signed authorization form with the completed/signed *Demand Response Physician Verification Form*.



DEMAND RESPONSE PHYSICIAN VERIFICATION FORM

Dear Physician,

As part of the applicant's *Demand Response Eligibility Application*, you are being asked to provide information about his/her disability and functional abilities. Demand Response Service, the Redding Area Bus Authority (RABA) Americans with Disabilities Act (ADA) paratransit service, is an origin-to-destination, shared ride, advanced reservation service for persons with disabilities who are functionally unable to use Fixed Route Bus Service. Eligibility for Demand Response Service is not granted because a person finds it difficult or uncomfortable to get to/from bus stops or to ride the bus. Likewise, age and disability do not confer eligibility. Persons must be functionally unable to utilize the Fixed Route Bus System.

RABA will use this information to determine eligibility for Demand Response Service. If you have questions about the eligibility process, please call the RABA ADA Paratransit Eligibility Office at (530) 225-4170.

1. Complete for All Applicants: Applicant Summary

Applicant's Name _____ Date of Birth _____

1. In what capacity do you know the applicant? _____

2. When was your last evaluation of the applicant? _____

3. What is the applicant's disability?

Intellectual, cognitive, or vision disability

Other impairment disability: _____

Impairment disability includes any loss or abnormality of psychological (mind), physiological (organ/cell/tissue/system), or anatomical (body) structure or function.

Not disabled

4. Does the applicant have the ability to:

Travel alone? Yes ___ No ___ Don't Know ___

Understand and follow a bus schedule? Yes ___ No ___ Don't Know ___

Communicate needs? Yes ___ No ___ Don't Know ___

Wait at a bus stop for 10-15 minutes? Yes ___ No ___ Don't Know ___

Grasp tickets or dollars/coins? Yes ___ No ___ Don't Know ___

Stand/maintain balance on a moving bus if holding a rail/pole? Yes ___ No ___ Don't Know ___

5. Does the applicant take medications that would affect his/her ability to travel on the bus?

Yes ___ No ___ If yes, explain: _____

6. Does the applicant's disability functionally prevent them from using Fixed Route Bus Service?

Yes ___ No ___ Not Disabled ___

**If "yes," explain in Section 2, 3, 4, and/or 5, then complete Sections 6 and 7.
If "not disabled," skip to and complete Sections 6 and 7.**

2. Complete if the Applicant has an Intellectual or Cognitive Disability

1. Describe how this disability functionally prevents the applicant from using Fixed Route Bus Service:

2. Does the applicant rely upon the assistance of a personal care attendant?

Yes ___ No ___ Don't Know ___ *If yes, explain:* _____

3. Does the applicant demonstrate behavioral or social problems (i.e., aggressive or overly friendly)?

Yes ___ No ___ Don't Know ___ *If yes, explain:* _____

3. Complete if the Applicant has a Vision Disability

1. Describe how this disability functionally prevents the applicant from using Fixed Route Bus Service:

2. Does the applicant use mobility aids?

Yes ___ No ___ *If yes, circle those used:*

Cane or Pedestrian Aid / Guide Animal / Braille Signs or Labels / Magnifier / Electronic Device / Other

3. Is this visual impairment temporary?

Yes ___ No ___ Don't Know ___ *If yes, how long will it last:* _____

4. Complete if the Applicant has a Mobility Impairment

1. Describe how this disability functionally prevents the applicant from using Fixed Route Bus Service:

2. Does the applicant use mobility aids?

Yes ___ No ___ *If yes, circle those used:*

Manual Wheelchair / Electric Wheelchair / Electric Scooter / Cane / Walker / Crutches / Leg Braces / Other

3. How far can the applicant walk with their mobility aid or travel in their wheelchair/scooter?
 Less than 1 block ___ 1-2 blocks ___ 3-6 blocks ___ 7+ blocks ___ Don't Know ___
4. Is this mobility impairment temporary?
 Yes ___ No ___ Don't Know ___ *If yes, how long will it last.* _____

5. Complete if the Applicant has Other Impairment

1. Describe how this disability functionally prevents the applicant from using Fixed Route Bus Service:

2. Does the applicant demonstrate behavioral or social problems?
 Yes ___ No ___ Don't Know ___ *If yes, explain:* _____

6. Complete for All Applicants: Physician Certification

By my signature, I certify that this information is true and correct. I understand that all information will be kept confidential. Additionally, I understand that the falsification of information may be penalized, including the denial of service for the applicant.

Signature _____ Date _____

Name _____ California License # _____

Address _____

Phone _____

7. Complete for All Applicants: Return the Completed Form to RABA

By fax: (530) 241-4667

By mail: RABA Office
 3333 S. Market Street
 Redding, CA 96001