



1189 S. 2<sup>nd</sup> St., Abilene, TX 79602 • Office 325-676-6318 • Fax 325-676-6407

## CITYLINK ADA PARATRANSIT APPLICATION

CityLink certifies individuals for the Paratransit Service according to the “Americans with Disabilities Act of 1990” which defines the standards used to determine eligibility for the Paratransit Service.

The information obtained in this certification process will only be used by CityLink for the provision of transportation services. Information will only be shared with other transit providers to facilitate travel in other areas. The information will not be provided to any other person or agency. It is important that all parts of this application are completed. If the application is not complete, it will be returned to you and that will delay having your application processed.

Please have your attending physician or professional care provider complete and sign the forms that may apply to your disability.

It could take up to 21 days for us to process your application after your completed application is submitted. You may mail your completed application or FAX your application to 676-6407.

Individuals with disabilities who are Medicaid Recipients may be eligible for free transportation to doctor/medical appointments through a state wide Medical Transportation Program. For more information call 877-633-8747.

Paratransit service trips are more specialized than the fixed route bus service trips, and therefore the fare structure is different. Current fares range between \$1.50 and \$2.25 per one-way trip.

Should you have any questions regarding the certification process please feel free to call our office at 676-6318.

Sincerely,  
CityLink Paratransit Staff

*DO NOT WRITE IN THIS SPACE OFFICE USE ONLY*

**DATE RECEIVED:** \_\_\_\_\_ **Assessment Date:** \_\_\_\_\_

**Determination Date:** \_\_\_\_\_ **Expiration Date:** \_\_\_\_\_



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## CITYLINK ADA PARATRANSIT APPLICATION

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Last Name \_\_\_\_\_

Street Address \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number (daytime) \_\_\_\_\_ (evening) \_\_\_\_\_

Date of Birth (month/day/year) \_\_\_\_\_ Sex (M/F) \_\_\_\_\_

Name and phone number of a friend or relative we can call in case of emergency or if we are unable to reach you at your regular number:

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

If some one is assisting you in completing this application, please identify:

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

Is this a request for temporary van service?  YES  NO

Is this a re-certification for van service?  YES  NO

Have you applied for ADA eligibility previously?  YES  NO

1. What type or types of disabilities prevent you from using the accessible fixed route bus service?

- Physical disability                       Mental Illness                       Seizure  
 Visual impairment/blindness     Developmental disability     Cognitive

Please describe your disability in more detail:

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2. Is the disability described above temporary or permanent?

- Permanent       Temporary, I expect it to last for another \_\_\_\_\_ months  
 I don't know

3. Do you use any of the following mobility aids? Check all that apply to you.

- Manual Wheelchair     Power Wheelchair     Walker                       Cane  
 Power Scooter             Crutches                       Service Animal  
 Portable Oxygen         3-Wheel scooter         None of these     Other

If you use a wheelchair/scooter, does your residence have a ramp? (Drivers will only assist a wheelchair up or down one (1) - 6" step)

- YES                                       No

**NOTE: We may not be able to accommodate you if your wheelchair or scooter is longer than 48 inches, wider than 32 inches, or if the total weight is more than 600 pounds**

4. Please explain the medical, health and/or disabling condition(s) that prevent you from using the regular bus service. (Please list all condition / disabilities that apply).

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5. Do you require a Personal Care Attendant (PCA) to travel with you to administer medical and/or communication assistance for you?

- YES, sometimes     YES, always     NO

## Disability or Health Condition Information

### 1. General Medical Conditions:

- None**    Kidney Dialysis    Cancer    Organ Transplant    Diabetes  
 Pneumonia    Other \_\_\_\_\_

How does this condition affect your ability to ride the regular CityLink Bus?

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### 2. Bone and Joint Conditions:

- None**    Fusion    Arthritis    Rheumatoid Arthritis    Osteo-arthritis  
 Osteoporosis    Amputation    Scleroderma  
 Broken Bone \_\_\_\_\_ When? \_\_\_\_\_  
 Other \_\_\_\_\_

How does this condition affect your ability to ride the regular CityLink Bus?

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### 3. Brain/Nerves/Muscle Conditions:

- None**    Cerebral Palsy    Spina Bifida    Multiple Sclerosis  
 Post Polio    Parkinson's disease    Alzheimer's disease    Epilepsy  
 Brain Injury    Quadriplegia    Dementia    Stroke (When? \_\_\_\_\_)  
 Vertigo/Dizziness    Seizure Disorder    Other \_\_\_\_\_

How does this condition affect your ability to ride the regular CityLink Bus?

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### 4. Heart and Circulatory Conditions:

- None**    Angina    Heart Attack    Congestive Heart Failure  
 Edema    Heart Surgery    High Blood Pressure  
 Peripheral Vascular Disease    Other \_\_\_\_\_

How does this condition affect your ability to ride the regular CityLink Bus?

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5. Lung and Breathing Conditions:

- None**       Allergies     Asthma     Emphysema  
 Lung Cancer    Cystic Fibrosis    Pulmonary Disease (COPD)  
 Other \_\_\_\_\_

How does this condition affect your ability to ride the regular CityLink Bus?

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6. Vision/Hearing/Speech Conditions:

- None**       Deaf     Glaucoma     Partially Sighted  
 Deaf-Blind    Hard of Hearing    Night Blindness    Partially Sighted  
 Registered Legally Blind    Cataracts     Dementia  
 Diabetic Retinopathy    Other \_\_\_\_\_

How does this condition affect your ability to ride the regular CityLink Bus?

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7. Developmental/Mental Conditions:

- None**       Autism     Glaucoma     Partially Sighted  
 Developmental Disability:    Mild    Moderate    Severe  
 Mental Retardation:             Mild    Moderate    Severe  
 Mood Disorder    Psychosis    Thought Disorder  
 Other \_\_\_\_\_

How does this condition affect your ability to ride the regular CityLink Bus?

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8. Are there other effects of your disability that we need to be aware of?

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**General Information**

1. Do you participate in a work activity or workshop?

- YES                       NO

If yes, which one? \_\_\_\_\_

2. Do you attend a daycare center or participate in a residential care or day treatment program?

- YES                       NO

If yes, which one? \_\_\_\_\_

3. Do you receive dialysis treatment?

- YES                       NO

If yes, where and when? \_\_\_\_\_

10. Do you reside at an assisted living facility or at a nursing home?

- YES                       NO

If yes, which one? \_\_\_\_\_

11. List three of your most frequent destinations, and how you may travel.

ADDRESS	FREQUENCY	HOW DO YOU TRAVEL?
1.) _____		
2.) _____		
3.) _____		

## **MOBILITY INFORMATION**

1. Have you ever used CityLink fixed route buses?  YES  NO

**2. When are you UNABLE to use the CityLink fixed-route bus?**

(please indicate below the following situations that apply to you)

- I can use CityLink regular bus service for some trips, but other times there are barriers that prevent me from using the bus.
- I have difficulty understanding and/or remembering all of the things I would have to do to find my way to and from the bus.
- I have difficulty getting to and from bus stops because I become disoriented easily.
- I can only get to and from bus stops if the distance is not too great and there are curb cuts and sidewalks on the route.
- I can only wait at CityLink bus stops if there is a bench or shelter.
- The severity of my disability can change from day to day. I can ride the bus only when I am feeling good.
- I cannot cross busy streets and intersections.
- I have difficulty or cannot climb stairs and can only board a CityLink bus if it has a lift or ramp.
- I have a health condition and cannot ride the bus if the walk is too far or if the weather is too hot.
- I can never use the CityLink bus service by myself.

3. Using a mobility aid or on your own, how many block can you go on level ground?

- 0 blocks  1 block  2 to 4 blocks  more than 4 blocks

4. If you use a wheelchair or scooter to ambulate, how far are you able to wheel or propel yourself without the assistance of another person?

- less than 200 feet  1 – 2 blocks  3 – 4 blocks  
 5 – 6 blocks  7 – 8 blocks  9 or more blocks

5. Is your ability to independently travel these distances affected by snow, ice, steep hills or other barriers?

- YES  NO

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

6. Are you able to get on and off a bus that has a lift?  YES  NO

**\*\*Please Note:** Persons who do not use wheelchairs, but who cannot climb steps are permitted to enter the vehicle by standing on lift.

7. Can you climb three (3) – 10” steps without assistance?  
 YES  NO SOMETIMES

**If sometimes please explain:** \_\_\_\_\_

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8. Are you able to wait outside in all weather conditions without support or at least 20 minutes?  YES  NO SOMETIMES

**If sometimes please explain:** \_\_\_\_\_

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Have you ever had any personal instruction on how to use CityLink fixed route bus service?  YES  NO

If yes, please indicate when and where: \_\_\_\_\_

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**CityLink Transit has a program available that is personalized instruction that teaches the skills necessary to use the regular fixed route system.**

**This training can be provided to you, free of charge.**

**If you are interested in learning more about this program, please indicate this below or call (325) 676-6318.**

**Yes, I would be interested in learning about the travel-training program.**

Please answer all of the following questions.

I understand my rights and responsibilities for CityLink Service and they are:

1. CityLink is public transportation and I will be sharing rides with other passengers.
2. CityLink does not provide emergency service.
3. I must pay the fare each time I ride
4. Three “No Shows” in 30 days could result in ridership suspension.\*
5. CityLink has 15 minutes before and 15 minutes after the scheduled pick-up time to arrive.
6. CityLink will wait only 5 minutes from the time it arrives.

I certify that the information provided in this application is accurate. I understand that false information may result in the denial or annulment of CityLink service. I further understand that all information will be kept confidential, and only the information required to provide the services I request will be disclosed to those who perform those services.

Applicant’s Signature \_\_\_\_\_ Date \_\_\_\_\_

*\* To be provided in the near future to help better assist our passengers and to improve a better quality of service.*



Thank you for your interest in the CityLink Paratransit Service. This concludes the portion of the application to be completed by the applicant.

**The last section of this application must be completed and signed by a qualified or a licensed professional. Please complete the forms that may apply to your disability.**

Example of qualified professionals include:

Physician (M.D. or D.O.)

Physical Therapist

Occupational Therapist

Registered Nurse

Optometrist

Psychologist

Return the completed form(s) to our office at your earliest convenience. It could take up to 21 days for us to process your application after your application is submitted. You may mail your completed application or FAX your application to (325) 676-6407.

If you have questions or need our assistance, we can be reached at (325) 676-6318.

Sincerely,

CityLink Paratransit Staff



1189 S. 2<sup>nd</sup>, Abilene, TX 79602 325-676-6318 (office) 325-676-6407 (fax)

**Professional Verification Form  
COGNITIVE**

Name of Applicant / Patient: \_\_\_\_\_

Name and Title of Professional: \_\_\_\_\_

Office / Business Name: \_\_\_\_\_

Office / Business Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Affiliation with Applicant / Patient: \_\_\_\_\_

1. In what capacity do you know the applicant?

\_\_\_\_\_  
\_\_\_\_\_

2. How long have you known or worked with the applicant? \_\_\_\_\_

3. When did you last see or treat the applicant? \_\_\_\_\_

4. Does the applicant have any specific behavioral problems?  Yes  No

\_\_\_\_\_  
\_\_\_\_\_

5. What abilities does the applicant have to recognize and avoid dangers in the community if he/she were to be traveling on their own?

\_\_\_\_\_  
\_\_\_\_\_

6. Describe the applicant's judgment and safety skills related to traveling alone.

\_\_\_\_\_

7. Describe the applicant's ability to concentrate. \_\_\_\_\_

\_\_\_\_\_

8. Describe the applicant's ability to process information. \_\_\_\_\_

\_\_\_\_\_

**Professional Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Print Signature:** \_\_\_\_\_



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**Professional Verification Form  
PHYSICAL DISABILITY**

Name of Applicant / Patient: \_\_\_\_\_

Name and Title of Professional: \_\_\_\_\_

Office / Business Name: \_\_\_\_\_

Office / Business Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Affiliation with Applicant / Patient: \_\_\_\_\_

1. In what capacity do you know the applicant? \_\_\_\_\_

2. How long have you known or worked with the applicant? \_\_\_\_\_

3. When did you last see or treat the applicant? \_\_\_\_\_

4. What is the diagnosis of the patient's disability? \_\_\_\_\_

5. This condition is:     Temporary         Permanent

6. If temporary, what is the approximate duration: \_\_\_\_\_

7. What is the prognosis? \_\_\_\_\_

8. Please describe the applicant's ability to travel alone in the community? \_\_\_\_\_

9. What advice or limitations on traveling alone in the community have been communicated to the applicant / patient? \_\_\_\_\_

10. Does the applicant / patient take medication for his/her condition? Yes    No

11. Is there anything about the use of medication that would complicate the individual's use of public transportation? \_\_\_\_\_

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12. Please describe the reasonable expectation of the patient to do the following:

<b>Travel Skills and Abilities</b>	<b>Reasonable Expectations</b>
Stepping on/off curbs and crossing streets	
Boarding lift and non-lift buses	
Regular exposure to extreme heat/humidity	
Regular exposure to cold weather	
Traveling in ice and/or snow	
Being outside in poor air quality	
Other	

**Professional Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Print Signature:** \_\_\_\_\_



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**Professional Verification Form  
PSYCHIATRIC**

Name of Applicant / Patient: \_\_\_\_\_

Name and Title of Professional: \_\_\_\_\_

Office / Business Name: \_\_\_\_\_

Office / Business Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Affiliation with Applicant / Patient: \_\_\_\_\_

1. In what capacity do you know the applicant?

\_\_\_\_\_  
\_\_\_\_\_

2. How long have you known or worked with the applicant? \_\_\_\_\_

3. When did you last see or treat the applicant? \_\_\_\_\_

4. What is the formal diagnosis of the applicant's disability (DSM-IV or other)?

\_\_\_\_\_  
\_\_\_\_\_

5. What was the date of onset? \_\_\_\_\_

6. What is the prognosis? \_\_\_\_\_

\_\_\_\_\_

7. Is the applicant taking any psychotropic, antidepressant or other medications prescribed by you?

Yes       No

Medication Type	Dosage	Functional Affect

8. Do you believe the applicant to be compliant in taking prescribed medication?

Yes       No       Sometimes

9. Is there anything about the use of medication that would complicate the applicant's use of public transportation?  Yes       No

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10. Would the use of alternative transportation (ADA paratransit service) conflict with the goals of therapy, such as confidence building?       Yes       No

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11. Does the applicant demonstrate inappropriate social behavior (for example, is he/she aggressive or overly friendly)?       Yes       No

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12. Are any of the following affected by the applicant's disability?

	Yes	No	Sometime	Comments
Seek and act on directions				
Find way to / from bus stop				
Cross the street				
Board the correct bus				
Exit at the correct destination				
Transfer to a second bus				
Monitor time				
Deal with unexpected situations				
Recognizing a problem				
Problem solving				
Coping skills				
Concentration				
Distractibility				

**Professional Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Print Signature:** \_\_\_\_\_



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**Professional Verification Form  
SEIZURE**

Name of Applicant / Patient: \_\_\_\_\_

Name and Title of Professional: \_\_\_\_\_

Office / Business Name: \_\_\_\_\_

Office / Business Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Affiliation with Applicant / Patient: \_\_\_\_\_

1. In what capacity do you know the applicant? \_\_\_\_\_

2. How long have you known or worked with the applicant? \_\_\_\_\_

3. When did you last see or treat the applicant? \_\_\_\_\_

4. How often do seizures occur? \_\_\_\_\_

5. What is the prognosis? \_\_\_\_\_

6. Are there certain things that will trigger the applicant's seizures? \_\_\_\_\_

7. Please describe the applicant's ability to travel alone in the community? \_\_\_\_\_

8. What advice or limitations on traveling alone in the community have been communicated to the applicant / patient? \_\_\_\_\_

9. Does the applicant / patient take medication for his/her condition? \_\_\_\_\_

10. Is there anything about the use of medication that would complicate the individual's use of public transportation? \_\_\_\_\_

**Professional Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Signature:** \_\_\_\_\_



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**Professional Verification Form  
VISUALLY IMPAIRED**

Name of Applicant / Patient: \_\_\_\_\_

Name and Title of Professional: \_\_\_\_\_

Office / Business Name: \_\_\_\_\_

Office / Business Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Affiliation with Applicant / Patient: \_\_\_\_\_

1. In what capacity do you know the applicant?  
\_\_\_\_\_

2. How long have you known or worked with the applicant? \_\_\_\_\_

3. When did you last see or treat the applicant? \_\_\_\_\_

4. What is the formal diagnosis of the applicant's eye disease or condition?  
\_\_\_\_\_

5. What was the date of onset? \_\_\_\_\_

6. What is the prognosis? \_\_\_\_\_

7. Is the applicant able to walk outdoors alone?  
 Yes       No       Sometimes       Often       Never

Comments: \_\_\_\_\_  
\_\_\_\_\_

8. If partially sighted, is the applicant able to see steps or curbs?  
 Yes       No       N/A

9. If partially sighted, is the applicant's vision affect by different lighting conditions?  
 Yes       No       N/A

**Professional Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Print Signature:** \_\_\_\_\_