



Call A Bus Paratransit Application

ColumBUS Call A Bus Paratransit service is designed for eligible riders who have a disability that sometimes or always prevents them from riding the fixed route bus. All of our fixed route buses are equipped with ramps for use with wheelchairs or scooters. Our buses also have a “kneeling” feature that lowers the bus closer to the ground to help people who have difficulty climbing stairs or stepping up. There is priority seating behind the driver for persons with disabilities and seniors. ColumBUS Transit offers free assistance and training to those interested in learning how to ride the fixed route buses.

Call A Bus service is designed for individuals who are unable to access ColumBUS Transit’s fixed route buses and are within a ¼ mile corridor of the fixed route buses. Call A Bus is a curb-to-curb service and drivers do not assist riders door-to-door. Simply having a disability or being inconvenienced or uncomfortable on the fixed route buses may not guarantee service. **Riders applying for this service must be unable to access fixed route buses due to conditions which prevent them from being able to get on, ride, or get off an ADA accessible, ramp equipped, kneeling vehicle.**

There are numerous types of eligibility that may be granted to a Call A Bus client including unconditional, conditional, permanent, and temporary. This application has two (2) parts and both must be completed or the application will be returned to the applicant. The questions contained herein are meant to determine the circumstances under which riders can use fixed route or Paratransit services. Eligibility to ride ColumBUS Call A Bus is granted for a period not to extend three (3) years at which time a new application (part 1) and Professional Verification endorsement (part 2) must be renewed. An applicant representative may NOT serve as the professional that completes part 2 of this application and applications must be submitted within thirty (30) days of signature of the Professional Verification endorsement (part 2).

ColumBUS Call A Bus will determine eligibility within twenty one (21) days of the submission of a completed application. ColumBUS Call A Bus will notify you in writing of the decision regarding your eligibility for Call A Bus service. If ColumBUS Call A Bus has not made an eligibility determination within twenty one (21) days, temporary eligibility will be granted until a decision is made. If it is determined applicants are not eligible for ColumBUS Call A Bus service, information on the appeal process will be provided with the notice of ineligibility.

ColumBUS Transit Call A Bus
850 Lindsey Street
Columbus, IN 47201
(812) 376-2506

callabus@columbus.in.gov

Applicant Questionnaire (Part 1)

Name _____ Date of Birth _____
Address _____ Apt _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Email Address _____
Emergency Contact _____ Relationship _____ Phone _____

If the applicant is being assisted with this application, the assistant must complete below:

Name _____ Daytime Phone _____
Address _____
Relationship to Applicant _____ Date _____
Email Address _____

To whom should we communicate with regarding eligibility, etc.? Please circle:

Applicant

Assistant

Other

If "other," please provide:

Name _____ Daytime Phone _____
Address _____ Email _____
Relationship to Applicant _____ Date _____

Information about disability and mobility equipment

What is the disability that prevents the applicant from using the ColumBUS Transit fixed route system? _____

- ☐ My disability is permanent
- ☐ My disability is temporary until ____/____ (month/year)
- ☐ My disability changes from day to day. Explain: _____

What mobility aid does the applicant use? (check all that apply)

- | | | |
|---|-------------------------------------|--|
| <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Portable Oxygen |
| <input type="checkbox"/> Motorized Wheelchair | <input type="checkbox"/> White Cane | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Service Animal | <input type="checkbox"/> Crutches | <input type="checkbox"/> Braces |
| | <input type="checkbox"/> Cane | <input type="checkbox"/> Other _____ |
- Wheelchair users:** _____ Length _____ Width _____ Weight _____

Disability Effect

- ☐ I have difficulty understanding or remembering schedule?
- ☐ I have difficulty finding my way to and from the bus.
- ☐ I have difficulty or cannot climb stairs and can only board a bus with a lift/ramp.

- ☐ I have a visual disability which prevents me from getting to and from the bus.
- ☐ My medical condition is such that I can't ride the fixed route bus if I'm not feeling well.
- ☐ My disability prevents me from getting to and from the bus stop.

Applicant's ability to use the ColumBUS Transit Fixed Route System

- 1) Can applicant cross the street by his/herself? (Yes/No/Sometimes) Explain: _____
- 2) When did applicant last use the fixed route system? _____ What Route? _____
- 3) What is the closest bus stop to applicant's home? (ex. 5th & Jackson) _____
- 4) Can applicant get to this stop independent of assistance from another person? _____

Please fill out this section if you have a visual impairment.

Name of Eye Disease/Condition: _____

My vision is worse during these conditions:

- ☐ Bright sunlight
- ☐ Dimly lit or shaded places
- ☐ Night time
- ☐ I have no vision at all

My eye condition is:

- ☐ Stable
- ☐ Degenerative
- ☐ I can see steps and curbs.
- ☐ I can see the route numbers on the bus from the bus stop
- ☐ I can find the bus stop without assistance.
- ☐ Other:

Additional Information

Please use this space to tell us anything else about travel challenges and applicant's ability to use the ColumBUS Transit fixed route service:

[illegible]

Information Release

In order for ColumBUS Transit to evaluate the applicant's part of the application, it may be necessary to contact someone who is familiar with the applicant's abilities. This does not need to be the person that fills out the Medical Professional's Questionnaire. This can be a Case Manager, a Social Worker, or an employer, for example. Please complete the following information and authorization.

The following professional is familiar with applicant's disability and functional abilities and is authorized to provide the required information to ColumBUS Transit.

Name _____
Address _____
Phone _____ Email _____

Applicant hereby certifies that the information given in this Questionnaire is correct. Applicant understands that if this application is found to be not eligible, applicant may appeal such determination within sixty (60) calendar days and that applicant will be advised of the procedures for such an appeal. Applicant hereby authorize ColumBUS Transit to contact the professional or agency listed above to verify functional abilities.

Applicant's Signature _____ Date _____
Witness (if assisted) _____ Date _____

The Americans with Disabilities Act (ADA) protects confidentiality. Following ADA guidelines, ColumBUS Transit considers all information including Call A Bus applications and associated paperwork confidential, including information riders may disclosed voluntarily.

ColumBUS Transit keeps all confidential materials in separate, locked files and restricts access to those that need to know in order to make necessary accommodations.

Medical Professional's Questionnaire (Part 2)

Your patient/client has requested eligibility for ColumBUS Transit Call A Bus ADA transportation service. Because of your professional relationship with this applicant, you are uniquely qualified to help clarify his or her **functional abilities and limitations**. The following are guidelines for using Call A Bus. ColumBUS Transit policy requires this information to be completed by a medical professional (Physician, Physician Assistant, Licensed Nurse, Physical Therapist, Rehabilitation Specialist, Licensed Psychologist, Licensed Counselor) who is not only familiar with the applicant's diagnosis, but who is also familiar with his/her mobility.

ColumBUS Transit fixed-route and Call A Bus Service

ColumBUS Transit offers two different types of transportation. ColumBUS Transit fixed-route service provides many accessibility features that make it possible for people with different types of disabilities to use it. These features include low-floor buses, bus kneeling, and low-slope boarding/alighting ramps (no steps), tie-downs and passenger restraints for wheelchairs, bus stop announcements, large print bus identification signs, priority seating, and alternative-format schedules.

Call A Bus Paratransit service provides curb-to-curb transportation on a shared-ride basis to eligible individuals whose disability prevents them from using the fixed-route bus transportation at all, or under certain circumstances.

Call A Bus is based on ADA eligibility which includes consideration for **Functional ability** to independently perform the tasks necessary for bus use including getting to and from the bus stop, getting on the bus, riding the bus and understanding how to navigate the system in a variety of environments, whether the disability **prevents** the individual from performing these tasks (as opposed to the task being inconvenient or difficult) as well as whether the individual can perform these tasks **all of the time, only under some circumstances, or never**. A diagnosis by itself does not qualify an individual for Call A Bus.

Please relate your comments as to how this individual's physical, sensory, cognitive or emotional problems may impact his/her ability to travel on a bus or relate to specific tasks necessary to get to and from a bus stop, board, ride and navigate the ColumBUS Transit fixed route system

If you have any questions regarding this Questionnaire, please contact ColumBUS Transit at (812) 376-2506. Thank you!

Please email or mail application to:

ColumBUS Transit Call A Bus
850 Lindsey Street
Columbus, IN 47201
(812)376-2506

callabus@columbus.in.gov

PROFESSIONAL VERIFICATION (Part 2)

Applicant's Name _____ Date of Birth _____

Date of last face-to-face contact (by you or your agency)? _____

Primary Diagnosis: _____

Current treatment: _____

Prognosis: _____

Secondary Diagnosis: _____

Medication's effect on the individual's ability to travel independently: _____

Can the walking applicant:

- | | |
|---|--|
| <input type="checkbox"/> Navigate around small objects | <input type="checkbox"/> Negotiate uneven/grassy surfaces |
| <input type="checkbox"/> Step up a 6" curb | <input type="checkbox"/> Negotiate gravel surfaces |
| <input type="checkbox"/> Step down a 6" curb | <input type="checkbox"/> Negotiate loose dirt/sand surfaces |
| <input type="checkbox"/> Negotiate sidewalks in good condition | <input type="checkbox"/> Walk up a 16' reasonable slope |
| <input type="checkbox"/> Negotiate broken pavement | <input type="checkbox"/> Wait without a bench for 10 minutes |
| <input type="checkbox"/> Mobility aid(s) used by the applicant: Type? _____ No. of years: _____ | |

How many blocks can the applicant travel in good conditions with the use of a mobility aid?

- ☐ Less than one
☐ One to two
☐ Up to four (1/4 mile)

Can the mobility-aided applicant:

- | | |
|---|---|
| <input type="checkbox"/> Maneuver onto a low-floor bus ramp | <input type="checkbox"/> Negotiate down a curb ramp |
| <input type="checkbox"/> Negotiate up a curb ramp | |

Are any of the following conditions affected by the applicant's disability? (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Orientation | <input type="checkbox"/> Gait or balance | <input type="checkbox"/> Sensitivity to cold weather |
| <input type="checkbox"/> Short-term memory | <input type="checkbox"/> Sense of time | <input type="checkbox"/> Sensitivity to hot weather |
| <input type="checkbox"/> Long-term memory | <input type="checkbox"/> Communication Sensitivity | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Other (Please explain) _____ | | |

Are any of the following conditions observed from the applicant? (check all that apply)

- ☐ High day-to-day variability in disability ☐ Seizures: Type: _____

I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature _____ Date _____

Printed Name _____ Licensed Title _____

Agency _____ Address _____

Phone _____ Email _____