Citylink Edmond
27 W. 3rd Street
Edmond, OK 73013
Customer Service: (405) 509-6370
Fax (405) 509-6371
citylinkedmond@gmail.com

OFFICE USE ONLY
Determination of ADA Eligibility

Date: _____

Reviewed By: _____

Approved: Yes No

Application for Citylink Access Paratransit Service

PART I – General Information to be completed by applicant
(Please Print or Type)

First Name	Middle	Last Name	Date of Birth

Street Address	Bldg & Apt. #	Name of Apt. or Living Center

City	State	Zip Code

Home Phone	Work Phone	Cell Phone

In Case of Emergency, please notify:

Name	Relationship	Phone Number(s)

Name	Relationship	Phone Number(s)

PART II – Information on disability and mobility equipment

Please briefly describe the disability that prevents you from using regular bus service:

_____

Is your disability permanent? ☐Yes ☐No
If not, expected duration of your disability? # weeks:____ # months:____

Have you ever had a seizure? □Yes □No
If yes, what type? _____ How often? _____
Are seizures controlled with medication? □Yes □No

Do you use any of the following mobility aids? (Check all that apply)

□ Manual Wheelchair	□ Walker	□ Service Animal
□ Powered Wheelchair	□ Cane	□ Portable Oxygen
□ Powered Scooter	□ Braces	□ Crutches
□ Prosthesis	□ Other _____	

PART III – Questions on using Citylink fixed route bus service

1. Have you ever used Citylink's fixed-route bus service? □ Yes □ No
   If no, are you prevented from traveling to or from a bus stop boarding location for one or more of the following reasons? Please mark all that apply.
   - □ Inability to negotiate hilly or rough terrain
   - □ Extreme sensitivity to climatic conditions
   - □ Allergic/Environmental sensitivities
   - □ Hyper-fatigue, frailty
   - □ Night Blindness
   - □ Inability to cross busy intersections
   - □ Inability to climb three 10-inch steps into bus
   - □ Bus stop too far away
   - □ Lack of sidewalk or handicap ramp
   - □ Other _____

2. Are you able to travel to the nearest bus stop? □ Yes □ No
   If no, please explain: _____

3. Are you able to use railings and handles? □ Yes □ No
   If no, please explain: _____

4. Are you able to keep balance while seated on a moving bus? □ Yes □ No
   If no, please explain: _____

5. Are you able to understand bus schedules? □ Yes □ No
   Understand and follow directions? □ Yes □ No
   Process information to ride Citylink? □ Yes □ No

6. Are you able to perform the following functions without supervision?
   a) Find your way between familiar locations?
   □ Yes □ No □ Yes, with training

   b) Signal the bus driver to get off at a familiar stop and get off the bus there?
   □ Yes □ No □ Yes, with training

   c) At a bus stop served by more than one bus route, can you distinguish the correct bus to board and indicate your intention to board?
   □ Yes □ No □ Yes, with training

7. Are you able to wait outside for 10 minutes? □ Yes□ No□ Sometimes

8. Are you able to perform the following functions without the assistance of another?
   - □ Travel 200 feet (the length of a city block)
   - □ Travel ¼ mile (the length of three city blocks)

9. Do you have trouble standing for more than 15 minutes?
   □ Yes □ No □ Sometimes

10. Are you able to cross the street of a busy intersection by yourself?
   □ Yes □ No

11. If bus travel training were available, would you be interested in participating?
   □ Yes □ No

12. Please read the following statements and check those which best describe what you believe is your ability to use a Citylink bus without assistance. You may select more than one.

   1. _____I can use the Citylink bus for some trips, but not at other times because there are barriers that prevent me from using the system.
   2. _____I use the Citylink bus service frequently.
   3. _____I have difficulty understanding and remembering all the things that I would have to do to find my way to and from the bus.
   4. _____I believe I could learn to ride the bus, if someone taught me.
   5. _____I have a visual disability can change from day to day. I can ride the bus only when my vision is well.
   6. _____The severity of my disability can change from day to day. I can ride the bus only when I am feeling well.
   7. _____I can never use the bus by myself.
   8. _____I can get to and from the bus if the distance is not too great and the route is barrier-free.

13. List three of your most frequent destinations, and how you get there?

Destination	Frequency of travel	How do you get there now?

PART IV – Please <u>initial</u> all the following statements indicating you have read and understand each statement.

By initialing, I indicate understanding of my rights and responsibilities for Citylink Access Paratransit Service and they are:

1. _____CAPS is public transportation and I will be sharing rides with other passengers.
2. _____CAPS is <u>NOT</u> an emergency provider.
3. _____Four (4) "No shows" in 30 days could result in suspension of service. A "No Show" is when a client does not give Citylink at least one-hour before scheduled pick-up time notice of a trip cancellation.
4. _____CAPS operators may arrive 15 minutes before of 15 minutes after the scheduled pick-up time.
5. _____CAPS operators will only wait 5 minutes from the time they arrive.
6. _____Wheelchair lifts can accommodate up to the weight limit set for each lift by the manufacture and 32 inches in width. I understand the combined weight of me, my wheelchair, and accessories must weigh less than lift restrictions. I also understand the width of my wheelchair cannot exceed 32 inches.
7. _____Just like our fixed routes, you are allowed to carry only what you can carry-on and store within the area in which you are seated in one trip. Multiple trips to carry on items will not be permitted.

I certify the information provided in this application is accurate. I understand that false information may result in the denial or annulment of 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

** If someone else has assisted the applicant in completing this application, that person must complete the following:

_____

Name Relationship Phone Number

_____ _____

Signature Date

Citylink Edmond
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Edmond, OK 73003
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Physician Verification of Disability Form for Citylink Access Paratransit (CAPS)

Please Note: Incomplete forms will be returned to applicant.

Patient Name_____ Patient DOB _____

Patient's Address:_____

The person named above is ☐ **currently being treated** or ☐ **was formerly treated** by me. The person has informed me of his/her intent to apply for Citylink Access Paratransit Service (CAPS). The information provided in this form is intended to verify any medical or health conditions that **prevent** the applicant from using Edmond's Citylink fixed route bus service.

Please Check One: _____Physician
_____Licensed health Care Provider
_____Licensed Rehab/Social Worker

Medical diagnosis and explanation of condition causing disability:

_____
_____
_____

Disability Status (Select One):

☐ Patient will be temporarily disabled for: _____weeks _____months.
☐ Patient is considered permanently disabled.

Does the disability prevent the applicant from utilizing the Citylink fixed route services? If yes, please describe in detail:

_____
_____
_____

Can the applicant walk or wheel ¼ mile (3 blocks) without the assistance of another person?
☐ Yes ☐ No

Can the applicant climb three 10-inch steps with assistance? ☐ Yes ☐ No

Can the applicant wait outside without support for 15 minutes? ☐ Yes ☐ No

Is the applicant treated with dialysis? ☐ Yes ☐ No

Does the applicant have a hearing impairment? □ Yes □ No

Is the applicant able to recognize a destination or landmark? □ Yes □ No

Is the applicant able to give addresses and phone numbers upon request? □ Yes □ No

Is the applicant able to deal with unexpected situations or unexpected changes in routine? □ Yes □ No

Is the applicant able to ask for, understand, and follow directions? □ Yes □ No

Is the applicant able to safely and effectively travel alone through crowded and/or complex facilities? □ Yes □ No

Does the applicant require a personal care attendant? □ Yes □ No

The vehicle wheelchair lift will accommodate up to the weight limited set by each lift by the manufacture and are 32 inches in width. The applicant's weight is _____ lbs.

Mobility device make and model: _____

Based upon my professional knowledge and/or medical history of the applicant, I certify that the preceding information is true and correct.

_____ _____

Name (Please Print) Office Phone Number

_____

Office Street Address City State Zip Code

_____

State License Number (If Applicable)

_____ _____

Signature Date

Please return signed form to:

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THANK YOU!