San Miguel Authority for Regional Transportation (SMART)
ADA Complementary Paratransit Service
Lawson Hill Service

American's Disability Act (ADA) Complementary Paratransit service is provided to individuals who, because of an assessed disability, are unable to independently ride a bus, get on/off a bus, or get to/from a bus stop. ADA eligibility is a transportation decision, not a medical decision. Eligibility for ADA Complementary Paratransit service is not based solely on disability, age, income, medical diagnosis, or lack of transportation options in your area.

It is the policy of the San Miguel Authority for Regional Transportation (SMART) that no otherwise qualified person shall, solely by reason of a disability, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity undertaken by SMART that receives or benefits from Federal financial assistance. SMART will comply with all legal requirements of Federal and State laws and regulations as they pertain to individuals with disabilities. SMART provides quality transportation services without discrimination to all individuals, including individuals with disabilities.

SMART determines eligibility based on functional considerations and determines which individuals can most benefit from ADA Complementary Paratransit service, and which individuals can be best served by the regular accessible SMART bus services. Difficulty in using the fixed-route service, inconvenience, inexperience, and/or personal choice not to utilize those transportation modes is not necessarily an indicator of whether or not an individual is eligible to use ADA Complementary Paratransit service.

At no expense to the applicant, ADA Complementary Paratransit service requires that each individual participate in an in-person functional ability assessment, which will determine the "range of access" to ADA Complementary Paratransit service.

Once the completed application is received, SMART will provide a written determination of eligibility letter within twenty-one (21) days. The ADA Complementary Paratransit Coordinator will call the applicant and set up an appointment for the in-person functional ability assessment, within seven (7) days of receipt of application. *(At no expense to the applicant, ADA Complementary Paratransit service requires that each individual participate in an in-person functional ability assessment, which will determine the "range of access" to ADA Complementary Paratransit service.)*

Functional assessments will occur at various locations, depending on the service area being requested.

A valid picture identification is required at the time of assessment.

Please return completed application to:
San Miguel Authority for Regional Transportation (SMART)
ADA Complementary Paratransit Service Coordinator
PO Box 3140
Telluride, CO 81435
Email: david.averill@smarttelluride.com

**Please call (970) 239-6034, should you have any questions or require assistance completing this application.

ADA Complementary Paratransit Application

Please complete this application as thoroughly as possible and to the best of your ability. Every question must be answered in full. Once the completed application is received, you will be contacted to arrange an in-person functional ability assessment.

Last Name: _____ First Name: _____

Date of Birth: _____

Sex: ☐ Male ☐ Female

Phone Number(s): _____

Residential Address: _____

City: _____ State: _____ Zip: _____

Residential Address: _____

City: _____ State: _____ Zip: _____

Email address: _____

Preferred Contact Method: ◯ Phone ◯ Email ◯ Mail

In case of emergency contact:

Last Name: _____ First Name: _____

Phone Number(s): _____

Preferred written material sent:

☐ Regular Print ☐ Large Print ☐ Another Language (specify):

_____

☐ Other Format (i.e., email):

_____

THE FOLLOWING QUESTIONS MUST BE ANSWERED:

Current mode of transportation:

☐ SMART ☐ Taxi ☐ Medical Shuttle ☐ Ambulance ☐ Private Vehicle ☐ Other:

_____

What barriers prevent you from accessing transportation modes that are available in your area? _____

_____

How does this barrier prevent you from utilizing these transportation modes?

_____

_____

UNDERSTANDING YOUR TRANSPORTATION NEEDS AND TRAVEL CHALLENGES:

How far is the nearest bust stop to your residence (approximately): _____

Can you get to and from this bus stop? ◯ Yes ◯ No

Does your physical condition change making it impossible to use bus services on a given day? ◯ Yes ◯ No

In your opinion, is this inability: ◯ Temporary ◯ Conditional ◯ On-Going

When you travel, do you have/require assistance from a personal care attendant? ◯ Yes ◯ No

Can you walk or wheel, without assistance? ◯ Yes ◯ No

Do you or have you had seizures? ◯ Yes ◯ No

Can you get to and from the "curb" to your residence to access ADA Complementary Paratransit service?

◯ Yes ◯ No

Do you utilize any assistive devices for ambulation? *(Check all that apply)*

☐ Walker ☐ Portable Oxygen ☐ Cane ☐ Leg Brace(s)

☐ Hearing Aids ☐ Crutches ☐ Powered Scooter ☐ Service Animal

☐ Glasses ☐ Wheelchair ☐ Tap or Sweep Cane ☐ Prosthesis

☐ Other *(please specify)*: _____

If you utilize a wheelchair for mobility, is the combined weight of you and the wheelchair under 600 pounds?

◯ Yes ◯ No

On a given day can you (with/without) a mobility device (wheelchair, walker, etc.) *(Check all that apply)*:

☐ Get to the curb in front of your house ☐ Travel up to 1 block ☐ Travel up to 4 blocks

☐ Cannot travel outside your home *(explain)*: _____

Do you have a valid Colorado driver's license? ◯ Yes ◯ No

Have you voluntarily surrendered your Colorado driver's license? ◯ Yes ◯ No

PLEASE READ THE FOLLOWING STATEMENTS AND CHECK THOSE WHICH BEST DESCRIBE YOUR ABILITY TO USE FIXED-ROUTE BUSES: *(CHECK ALL THAT APPLY)*

☐ I can ride public transportation when I am feeling well. There are other times, however, when my disability or health conditions worsen and at those times I cannot ride public transportation.

☐ I have a disability or health conditions that prevent me from riding public transportation if the weather is very hot or very cold.

☐ I cannot climb stairs to get on or off a vehicle.

☐ I can get to and from the vehicle, only if there are curb-cuts and level sidewalks.

☐ I am not able to u se current transportation vehicles for other reasons. (explain): _____

_____

☐ My disability of health conditions makes it impossible to travel when there is snow or ice on the ground.

Are you able to ask the driver for assistance? ◯ Yes ◯ No

Can you grasp railings to get on and off the vehicle? ◯ Yes ◯ No

Can you pull cords or push the bell strip to let the driver know you wish to get off the vehicle?

Yes ◯ No ◯

Can you make a fare transaction/donation on a vehicle? ◯ Yes ◯ No

Do you have memory issues? ◯ Yes ◯ No

If yes, how do you compensate: _____

_____

What is the farthest you can walk outdoors? _____

PLEASE PROVIDE ADDITIONAL INFORMATION ABOUT YOUR FUNCTIONAL ABILITIES:

Can you…

Ask for and understand written or spoken instructions? ◯ Yes ◯ No

Cross the Street? ◯ Yes ◯ No

Stand for 10 minutes if there is no place to sit? ◯ Yes ◯ No

Step on and off a sidewalk from the curb? ◯ Yes ◯ No

Walk up and down 3 steps if there is a handrail? ◯ Yes ◯ No

Transfer from one vehicle to another? ◯ Yes ◯ No

PLEASE PROVIDE INFORMATION ABOUT WHERE YOU GO AND HOW YOU CURRENTLY GET THERE:

List your 1-2 most frequent destinations and how you currently get there…

Where do you go? _____

Address: _____

How often do you go there?

_____

How do you currently get there? _____

Where do you go? _____

Address: _____

How often do you go there?

_____

How do you currently get there? _____

Do you have a health care professional's report/verification to substantiate this request? *(Not a requirement)*

◯ Yes ◯ No

CERTIFICATION AND SIGNATURE

I understand that the purpose of this application is to determine if I am eligible to use the ADA Complementary Paratransit service. I certify that the information provided in this application is true and correct.

The Americans with Disabilities Act of 1990 is a Civil Rights Act that requires public transit agencies to provide services to people whose disabilities prevent them from accessing the public transportation system in their area. The information you provide will enable us to make an appropriate determination for you. All information will be kept confidential. Thank you for your assistance.

By signing this application, the applicant agrees to the following conditions:

1. An in-person functional ability assessment will be required, in addition to this completed application.
2. It will be my responsibility to obtain transportation, to and from, the in-person functional ability assessment, as well as, provide a valid picture identification at the time of assessment.
3. I may present verification, from a Personal Care Provider, verifying my assessed need for ADA Complementary Paratransit services.
4. If at any time I am no longer affected by the disability as described in this application, my eligibility for ADA Complementary Paratransit services will terminate.

_____	_____	_____
Printed Name	Signature	Date

If someone other than the applicant assisted in completing this application, please provide the following information:

Name: _____

Relationship to Applicant: _____

Address of Assistant: _____

Agency *(if applicable)*: _____

Contact information *(e-mail, phone, etc.)*: _____