APPLICATION FOR ALEXANDRIA DOT PARATRANSIT SERVICE

This form is for people who wish to apply for eligibility for paratransit service under the Americans with Disabilities Act (ADA). Individuals with disabilities that prevent them from being able to use transit may be eligible to use DOT Paratransit services. Eligible riders may be required to recertify every two years.

The information obtained in this application will only be used by the City of Alexandria to assess your eligibility and to ensure provision of appropriate transportation services.

Application Process

1. Fill out Part A of this application if you believe you qualify (see "Eligibility" below).
2. Complete i. or ii. below
   i. Provide a copy, scan, or photo of the front and back of your MetroAccess ID. DOT reserves the right to request a MetroAccess ID be shown in person to a designated staff.
   ii. Take or mail this application (Parts A and B) to your healthcare professional to have Part B completed.
3. Submit the completed application form (Parts A and B) to the City:

   Mail: **City of Alexandria**
   DOT Paratransit
   421 King Street, Suite 235
   Alexandria, VA 22314
   Fax: **703.746.6433**
   Email: **paratransit@alexandriava.gov**
4. DOT will notify you of your eligibility status.
5. **If you have not been notified within 21 days of submitting your application**, call 703.836.5222 Voice, or Virginia Relay 711. If determination of your eligibility has not been made, you will be temporarily eligible for paratransit service.

6. If you are denied eligibility, you have a right to appeal. Information on the appeals process will be sent to you. Call 703.836.5222 Voice; or Virginia Relay 711 for more information.

Eligibility

Under the ADA, there are three categories of persons who are eligible for ADA paratransit. Any individual with a disability qualifies who:

A. Is unable to get on, ride, or get off an accessible public transit vehicle due to a physical or mental impairment; or
B. Needs the assistance of a wheelchair lift or other boarding assistance device and is able with such assistance, to get on, ride, and get off an accessible vehicle, BUT such a vehicle is not available on the route when the individual wants to travel; or
C. Has a specific impairment-related condition (including vision, hearing or impairments causing disorientation) which prevents travel to or from a station or stop on the system.

Once your application is reviewed, DOT will designate a type of eligibility based on the person's functional ability to use public transportation, as follows:

- **Unconditional Eligibility** - An applicant whose disability prevents them from using the accessible fixed route bus system in all situations.
- **Conditional Eligibility** - An applicant whose disability prevents them from using the accessible fixed route bus system when specific circumstances are present.
- **Temporary Eligibility** - An applicant who is temporarily disabled and needs service for a short period of time.
- **Ineligible** - An applicant with a disability that does not prohibit him/her from using the accessible fixed route bus service under the definitions of the ADA. If an applicant is denied, DOT will provide a letter stating the reasons for the determination and explaining the process for filing an appeal.

Part A

Applicant Information

Name: _____ Date of Birth: _____
Last *First* *M.I.*

Address of where you will be residing when using the DOT service:

_____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Is the address provided your legal residence in the City of Alexandria?

☐ YES ☐ NO

If no, then provide your legal residence below:

_____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone:_____ Email:_____

Emergency Contact

In Case of Emergency, who should we contact?

Name:_____

Relationship (Family, Neighbor, etc.) _____

Phone (work): _____ Phone (cell): _____

Part A

Mobility Aids

Do you require the use of a mobility aid while traveling?

☐ YES ☐ NO

If yes, check all that apply:

☐ Manual wheelchair	☐ Service Animal	☐ Cane
☐ Powered wheelchair	☐ Oxygen Bottle	☐ White Cane
☐ Bariatric wheelchair over 30” wide and/or 42” long	☐ Communications board	☐ Walker
☐ Powered scooter	☐ Transfer board	☐ Crutches
☐ Hearing aid	☐ Boarding chair	☐ Prosthesis

☐ Other: _____

If you use a wheelchair or scooter, are you willing to transfer to a seat in the vehicle?

☐ YES ☐ NO

Personal Care Attendant

Do you require a Personal Care Attendant when you travel? (You are responsible for providing your Personal Care Attendant)

☐ YES ☐ NO

Disability Information

What is your disability? _____

_____

Is there anything else regarding your disability that we need to be aware of to provide appropriate paratransit service? Please provide any information that would help.

_____

_____

Travel Training

Travel training may help you use the fixed route bus and Metrorail systems for specific routes or for all routes. Travel training professionals may be available to work with you (and your specific disability) free of charge. For more information about travel training, call 703.836.5222 Voice, or Virginia Relay 711.

☐ Please check here if you are interested in travel training.

Applicant HIPAA Authorization

I, _____, authorize the healthcare provider completing this application to release to the City of Alexandria paratransit service, DOT, any protected health information about my disability in order to verify my eligibility for DOT paratransit service. I also authorize the release of further information should it be needed for this application for a period of 60 days from the date of my signature on Part A of this application.

Disclaimer and Signature

DOT reserves the right to require additional information from a healthcare provider. If DOT requires additional information from a healthcare provider, you will be notified and provided the required form for your provider to complete.

I certify that my answers are correct to the best of my knowledge.

_____

Signature Date

***OR** I am not the applicant, but have completed this application on the applicant's behalf, and certify that the application is correct to the best of my knowledge*:

_____

Signature Relationship to Applicant

_____

Printed Name Date Daytime Phone

Describe below how this person has legal authority to sign this form:

_____

_____

_____

Part B

Proof of Disability Impacting Access to Fixed Route Service

Have your healthcare provider complete the Healthcare Provider Certification below OR provide a copy, scan, or photo of the front and back of your MetroAccess ID.

DOT reserves the right to request a MetroAccess ID be shown in person to a designated staff. You will be notified if DOT requires your MetroAccess ID to be shown in person as part of your application review process.

Healthcare Provider Certification

Name of Healthcare Provider:

Phone:

License Number/ State or District Issued:

Street Address and Suite #:

City, State, Zip:

Specialization:

Part B

1. Does the applicant require a Personal Care Attendant when they travel?

   ☐ YES ☐ NO

2. Does the applicant require any mobility aids when riding paratransit?

   ☐ YES ☐ NO

   If yes, check all that apply:

☐ Manual wheelchair	☐ Service Animal	☐ Cane
☐ Powered wheelchair	☐ Oxygen Bottle	☐ White Cane
☐ Bariatric wheelchair	☐ Communications board	☐ Walker
☐ Powered scooter	☐ Transfer board	☐ Crutches
☐ Hearing aid	☐ Boarding chair	☐ Prosthesis

   ☐ Other: _____

3. What is the expected duration of the disability?

   ☐ Temporary: Expected duration until _____/_____/_____

   ☐ Long-term: Conditions with potential for improvement or long periods of remission.
   Expected duration until _____/_____/_____

   ☐ Permanent: Conditions with no expectation of improvement.

4. Does the applicant's disability(ies) prevent them from independently using the accessible DASH bus system for some or all trips?

   ☐ YES ☐ NO

   If yes, how does the disability impact the applicant's ability to travel independently on the accessible public transit system?

   _____

   _____

Part B

5. If the applicant is currently on medication(s), will the side effects significantly reduce or hinder their ability to independently ride the accessible public transit system?

   ☐ YES ☐ NO ☐ N/A

   If yes, please explain how the side effects would hinder the applicant's ability to use the accessible public transit system:

   _____

   _____

Based on the applicant's disability(ies), please explain if the following environmental factors affect their ability to ride the accessible public transit system.

6. Extremes in temperature

   ☐ YES ☐ NO

   Please explain how:

   _____

7. Ice and/or snow

   ☐ YES ☐ NO

   Please explain how:

   _____

8. Poor air quality

   ☐ YES ☐ NO

   Please explain how:

   _____

9. In your medical opinion, what other factors related to the applicant's disability(ies) affect their ability to ride the accessible transit system?

   _____

   _____

Part B

Healthcare Provider Signature Page

I certify that I have completed the questions in Part B and the information provided is true and correct.

Signature Date

Printed Name