# R-TRANSIT
# APPLICATION FOR SERVICES

## Connecting People to Places

## SUBMIT

**In Person:**
R-Transit Center
1600 Nevin Plaza
Richmond, CA 94801

**Hours:**
Monday – Friday
8:30 am – 5:00 pm
Excluding weekends & holidays

**By Mail:**
Attn: R-Transit
P.O. Box 4046
Richmond, CA 94804

**Phone:** (510) 307-8026

**Fax:** (510) 307-8080

**E-mail:** paratransitservices@ci.richmond.ca.us
**Website:** www.rtransit.com

**REGISTER, RESERVE, RIDE & REACH** YOUR DESTINATION WITH **R-TRANSIT**

Dear Applicant,

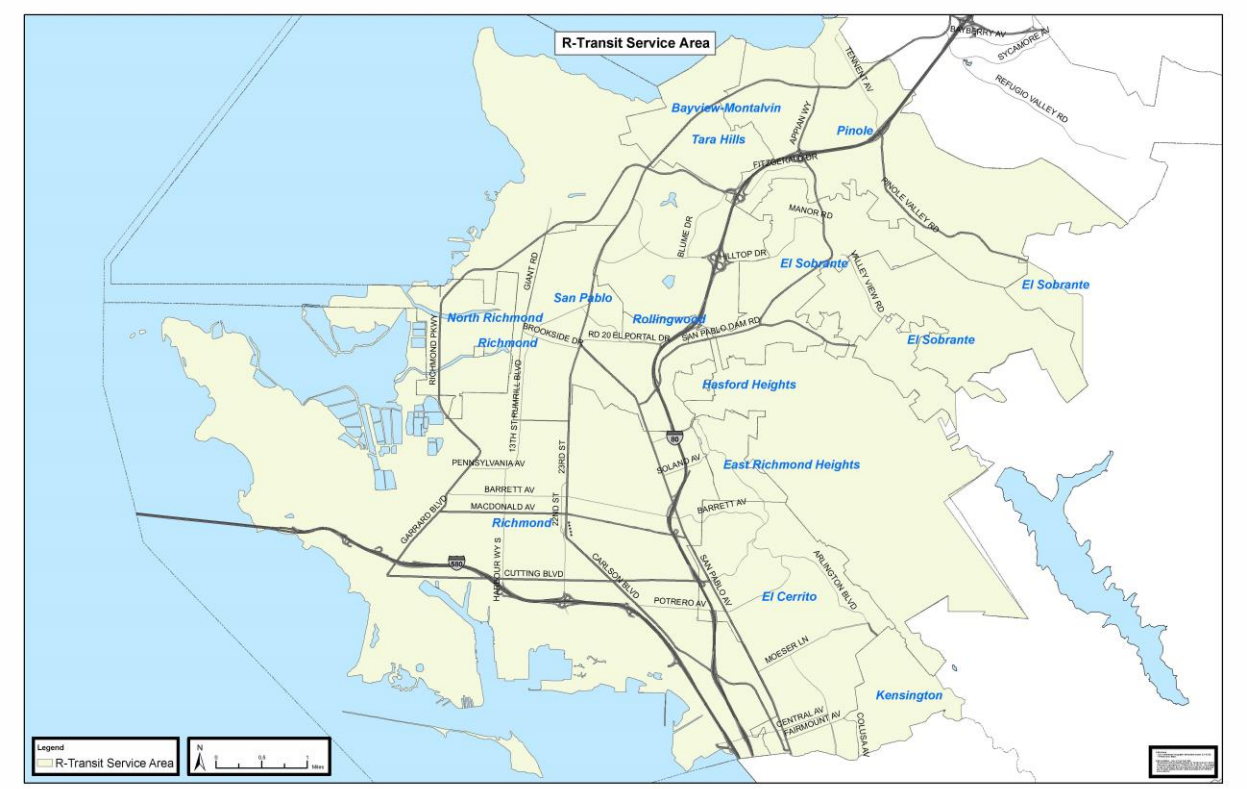
Thank you for your interest in the R-Transit program. This application form will assist R-Transit in establishing your eligibility for services. To qualify for R-Transit service, applicants must meet the criteria below:

1. Applicant must a resident of one of the following Cities/areas: Richmond, Kensington, El Sobrante, unincorporated communities of East Richmond Heights, Hasford Heights, Rollingwood, or North Richmond.

2. Applicants between the ages of 18-54 must provide proof of disability and meet the residency requirement; applicants ages 55 or older qualify as long as the residency requirement is satisfied.

Using the eligibility requirements established by R-Transit, you will either be certified eligible for all services, eligible on a temporary basis or denied eligibility altogether.

Once certified, you will be able to travel to destinations within our service area:




Upon receipt of a completed application form, supporting documents, your application will be processed within seven to ten business days. You will be notified by mail regarding your eligibility status. If eligible for service, you will receive an orientation guide with program details by mail.

You may complete the application yourself or obtain assistance from anyone familiar with you and your condition. Incomplete applications will be returned without being processed, so please be sure to complete yours in its entirety before mailing it. If no one is available to help you, and you would like our assistance, please contact the staff at (510) 307-8026.

**R-TRANSIT**
1600 Nevin Plaza
Richmond, CA 94801
(510) 307-8026
FAX (510) 307-8080

## APPLICATION FOR SERVICES

It is important to **complete all parts of this form** - type or please print legible.
***Applications that are not complete or clearly written will be returned, which will delay the eligibility determination process***

DATE _____

NAME _____ TELEPHONE #_____

ADDRESS_____ BIRTHDATE ___/___/___
MM DD YY

_____ ❑ **MALE** ❑ FEMALE

## SECTION I

### VALID IDENTIFICATION & PROOF OF RESIDENCY

Please provide a copy of an acceptable form of identification, **and** proof of residency:

| **Acceptable forms of Identification** | **Acceptable forms of Proof of Residency** |
|---|---|
| • An identification card or driver's license issued by the California Department of Motor Vehicles.<br>• An identification card or driver's license issued by another state.<br>• Valid Passport or Passport Card<br>• U.S. Active Duty/Retiree/Reservist Military ID Card<br>• Richmond Municipal ID Card | • Any piece of mail showing your name & address (i.e utility bill)<br>• Post Office (P.O Box) addresses are not acceptable. |

## SECTION II

### EMERGENCY CONTACT INFORMATION

Please provide a name and telephone number of a contact person in the event of an emergency.

NAME: _____ DAY PHONE :(___) _____

RELATIONSHIP: _____ EVE. PHONE :(___)_____

## SECTION III

**Please answer the following questions - your specific answers to the questions will help us in determining your eligibility**

1. What is your disability or health related condition that prevents you from using public transportation?

   _____

2. Explain how your disability or health related condition prevents you from independently using the public transit services (BART, AC Transit...etc.)

   _____

3. How do you currently travel to your destinations? Check all that apply.

   (____) Public Buses (____) Someone Provides Transportation (____) Drive Myself

   (____) Paratransit (____) Taxi (____) Ferry

   (____) BART (____) Other: _____

4. Do you use any of the following mobility aids or specialized equipment? Check all that apply.

   (____) Cane (____) Power Wheelchair (____) Communication Board

   (____) White Cane (____) Large Power Wheelchair (____) Service Animal

   (____) Walker (____) Power Scooter (3-wheeler) (____) Crutches

   (____) Leg Braces (____) Manual Wheelchair (____) Other Aid

5. If the passenger uses a wheelchair or scooter, does your residence have a ramp?
   (____) Yes (____) No

6. Does the wheelchair or scooter have a seatbelt?
   (____) Yes (____) No

7. If the passenger has a manual wheelchair, can it be folded?
   (____) Yes (____) No

8. Can the passenger transfer into a vehicle with minimal assistance?
   (____) Yes (____) No

9. Does a personal care attendant accompany you when you travel outside your home?
   (____) Yes (____) No

10. Have you recently applied for paratransit services with ***EAST BAY PARATRANSIT***?
    (____) Yes (____) No

    If yes, what is the status of your application?
    (____) Pending (____) Denied

11. Are you currently certified with ***EAST BAY PARATRANSIT***?
    (____) Yes (____) No

12. Have you terminated your eligibility status with ***EAST BAY PARATRANSIT***?
    (____) Yes (____) No

    If yes, what is your reason for the termination? _____

## SECTION IV

*Check the applicable box below:*

☐ I am age 55 or older. **Skip section below and proceed to Section V.**

☐ I am between the ages of 18-54. **Applicants between the ages of 18-54 must provide proof of disability. Submit a copy of one of the following:**

- Medicare card, federally issued red, white and blue card
- California DMV Disabled Placard Registration Parking placard receipt
- Regional Transit Connection (RTC) Clipper Card
- Proof of certification with East Bay Paratransit

If you are unable to provide any of the proofs listed above, you may complete the Authorization for Use or Disclosure of Patient Health Information form below. This form authorizes R-Transit to obtain information from your healthcare provider regarding your disability. This authorization form will be sent to healthcare provider along with a disability verification form.

**AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION**

I, _____, hereby authorize the following licensed professional (doctor, therapist, social worker, etc), who can verify my disability or health related condition, to release this information to R-Transit. This information will be used only to verify my eligibility for Paratransit services. I understand that I have the right to request a copy of this authorization, and that I may revoke it at any time.

This authorizes the following Medical Center(s) to complete **Disability Verification form**:

Medical Center: _____

Physician Name: _____ Physician Phone #: _____

Address: _____
Street Address Suite City, State Zipcode

**PATIENT INFORMATION**

Patient Name: _____ Patient Phone #: _____

Medical Record #: _____ Date of Birth: _____

Address: _____
Street Address Suite City, State Zipcode

**MEDICAL CENTER MAY DISCLOSE THIS INFORMATION TO:**

Recipient Name: R-TRANSIT Phone #: 510-307-8026 Fax #: 510-307-8080

Address: 1600 Nevin Plaza, Richmond CA 94801

DURATION: This authorization shall remain in effect for one year from the date of signature unless a different date is specified here: Date:

I certify that the information on this form is true and correct. I understand all information will be kept confidential and only information required to provide the service will be disclosed to those who perform the service. I understand that it will be necessary to contact a physician familiar with my functional abilities to use public transit in order to assist in the determination of eligibility.

_____ _____ _____
Print Name Signature Date

## SECTION V

### APPLICANT'S CERTIFICATION

I certify that the information in this application is true and correct. I understand that falsification of the information may result in denial of service. I understand all information will be kept confidential and only the information required to provide the services will be disclosed to those who perform the service

_____ _____ _____
Applicant's Name (print) Applicant's Signature Date

**Be sure to attach the following ☑:**
☐Proof of Identification ☐Proof of Residency ☐Disability proof or complete Section IV (*applicable to ages 18-54)*