



Application for Santa Ride Paratransit Service

This packet includes important information regarding your application for the Santa Fe Ride Program. The Santa Fe Ride Program provides transportation for individuals who are unable to independently use the regular public transportation, some or all of the time due to a disability or health related condition.

In order to use the Santa Fe Ride Program, you must be certified as eligible. Eligibility is determined on a case by case basis. According to ADA regulations, eligibility is strictly limited to those who have specific limitations that prevent them from using accessible public transportation.

By submitting your application you may be approved for full eligibility (unconditional) or on a limited basis for some trips only (conditional eligibility). If you are found to be capable of using regular bus and rail transit for all trips, without the help of another person, you will not be eligible for paratransit.

To determine if you are eligible for ADA Paratransit Service, please fill out the enclosed application completely, incomplete applications will be sent back. There is also a section for your health care provider to fill out. Please make sure that all questions are answered. **DO NOT ADD OR ALTER THE DOCTOR'S PORTION OF THE APPLICATION BY DOING SO IT WILL MAKE IT VOID AND IT WILL BE SENT BACK.** All information provided by the applicant will be kept strictly confidential. If you have any questions in filling out the application, please feel free to contact our office at (505) 473-4444.

Disability alone does not establish ADA paratransit service eligibility; the decision is based solely on the applicant's functional ability to use the Santa Fe Trails fixed-route transit service. Santa Fe ride is for those who do not have the functional abilities to access and ride the regular fixed-route transit service.

A completed application process can take up to twenty-one (21) calendar days of submission. If Santa Fe Ride has not made a determination of eligibility within 21 days of receiving a completed application, the applicant shall be treated as eligible and provided service until and unless Santa Fe Ride denies the application. Once we received the application we will contact you to come in for an interview to determine your eligibility. We will provide free transportation to and from the interview if needed. The Santa Fe Ride Program only transports in the City of Santa Fe city limits. Santa Fe Ride is an "origin to destination" service and curb to curb transportation is primary means by which service will be provided.

Thank you for your interest in the Santa Fe Ride Program, you can submit you application to Transit Service P.O. Box 909 Santa Fe, NM 87507 or bring into the office, or it can be faxed to (505) 955-2049.



Certification of ADA Paratransit Eligibility

The information obtained in this certification process will be used by the City of Santa Fe for the provision of transportation services. Information will only be shared with other transit providers to facilitate travel in those areas. The information will not be provided to any other person/agency.

- ☐ **First Time Applicant**
☐ **Renewal Applicant - Current Card # _____**

1. **Name** _____
2. **Address** _____ **City** _____ **State** _____ **Zip** _____
Mailing Address if Different _____ **City** _____ **State** _____ **Zip** _____
3. **Telephone Number (Home)** _____ **(Cell)** _____ **(Work)** _____
4. **Date of Birth** _____ / _____ / _____ **Female** ____ **Male** ____
5. **Check all that apply: Hispanic** ____ **Native American** ____
African American ____ **Asian** ____ **Caucasian** ____ **Other** ____
6. **Primary Language (please check)** **English** ____ **Spanish** ____ **Other (specify)** _____
7. **Veteran** ____ **Yes** ____ **No (check one)** **If yes please provide proper documentation**
8. **Which of the following best describes your disability?**
____ a. The condition I have prevents me from using the fixed route system (Santa Fe Trails Bus Service) permanently.
____ b. My condition is temporary and I should be able to use the fixed route system (Santa Fe Trails Bus Service) by _____ (date).
____ c. My condition is intermittent _____ % of the time and I will not be able to use the fixed route system (Santa Fe Trails Bus Service)
9. **Does your disability change from day to day or seasonally?**
____ **Yes** ____ **No**

If yes, Please explain: _____

10. Do the conditions you describe change from day-to-day in a way that affects your ability to ride the regular bus service?

☐ Yes, good on some days, bad on others ☐ No, doesn't change

☐ Don't know

11. How does this disability prevent you from using fixed route service (Santa Fe Trails Bus service)? Please explain completely. Use additional sheet if needed.

12. Would you be able to get to and from the public transit stop nearest your home?

☐ Yes ☐ No ☐ Sometimes

If no or sometimes, explain why?

13. How would you describe the terrain where you live? (e.g., flat, steep hills, gradual sloping hills,

etc.) _____

14. Does your disability make it difficult for you to understand and remember how to find your Way to and from the bus stop?

☐ Yes ☐ No

If yes, please explain: _____

15. Are there any other effects of your disability of which we need to be aware of?

The following information will be used to ensure that an appropriate vehicle is utilized to provide your transportation and that an accurate analysis of your trip requests can be made by the City of Santa Fe.

16. Do you use any of the following aids for mobility? (check all that apply)

<input type="checkbox"/> Manual Wheelchair	<input type="checkbox"/> Cane	<input type="checkbox"/> Service Animal
<input type="checkbox"/> Powered Scooter	<input type="checkbox"/> Walker	<input type="checkbox"/> Personal Care Attendant
<input type="checkbox"/> Electric Wheelchair	<input type="checkbox"/> Crutches	

17. If you use a wheelchair or scooter, is the combined weight of you and the device over 800 pounds?

☐ Yes ☐ No ☐ Not applicable

18. If you use a wheelchair or scooter, does your residence have a wheelchair ramp?

_____ Yes _____ No

If no ramp, how many steps? _____

If more than one step, how do you transport your wheelchair to the street level?

19. Do you require a personal Care Attendant when you travel using public transit?

_____ Yes _____ No

20. Please answer all of the following questions:

Can you travel one city block without the assistance of another person?

_____ Yes _____ No _____ Sometimes

Can you travel 5 city blocks without the assistance of another person?

_____ Yes _____ No _____ Sometimes

Can you climb three 12-inch steps without assistance?

_____ Yes _____ No _____ Sometimes

Can you wait outside without support for ten minutes?

_____ Yes _____ No _____ Sometimes

21. Which of the following statements best describes you if you had to wait outside for a ride?

(check only one response):

_____ I could wait by myself for ten to fifteen minutes with or without a mobile device

_____ I could wait by myself for ten to fifteen minutes only if I had a seat or mobile device and shelter

_____ I would need someone to wait with me because

22. I hereby certify that the information given above is correct.

Signed _____

Date ____ / ____ / ____

23. Name of Emergency Contact _____

Phone Number _____

24. If this application has been completed by someone other than the person requesting certification, that person must complete the following:

Name _____
Address _____
City _____ State _____ Zip _____ Phone _____
Signed _____ Date ____ / ____ / ____

**RETURN FORM TO: TRANSIT SERVICE
P.O. BOX 909
SANTA FE, NM 87504-0909**



RELEASE OF INFORMATION

In order to allow the City of Santa Fe to evaluate your request, it may be necessary to contact the physician or other licensed professional, to confirm the information they will provide when you submit the following the "Requested for Professional Verification". Please send complete applications only, incomplete applications will not be processed.

The person completing the "Request for Professional Verification" form is: (check one)

_____ Physician _____ Health Care Professional
_____ Rehabilitation Professional

This person is familiar with the effects of my disability and is authorized to complete the professional verification for of the City of Santa Fe required to complete this certification process.

Name _____
(Physicians or Professionals Name)

Address _____
(Physicians or Professionals Address)

City _____ State _____ Zip _____

Daytime phone _____ Fax Number _____

Signed _____ Date ____ / ____ / ____
(Applicant Name)



REQUEST FOR PROFESSIONAL VERIFICATION

THIS SECTION TO BE COMPLETED BY PHYSICIAN, NURSE OR STATE LICENSED SOCIAL WORKER. ANY ALTERATIONS, DELETIONS OR ADDITIONS BY APPLICANT SHALL MAKE THIS APPLICATION VOID.

Note: Questions #1 through #6 must be completed by **ONLY** the Physician, Nurse or State Licensed Social Worker to process the application. If the application is incomplete it will be mailed back.

Dear _____,
(Physician's Name)

The attached authorization form has been submitted by _____
(Applicant's Name)

has indicated that you can provide information regarding his/her disability and its impact upon his/her ability to utilize our fixed route transit service (Santa Fe Trails Bus Service). Federal law requires that the City of Santa Fe provide paratransit services to persons who cannot utilize available bus service (Santa Fe Bus Service). The information you provide will allow us to verify his/her medical condition and how it effect of their ability to get around on their own. Your evaluation of each person must be based solely upon their functional abilities to use regular fixed route transit service, not on their age or medical diagnosis. Thank you for your cooperation in this matter. **All questions must be answered for this form to be considered complete.** If you have any questions call (505) 955-2002.

1. Capacity in which you know the applicant:

I am his/her _____.
(patient's name)

2. Which of the following best describes your client's (patient's) disability?

- _____ a. The condition is permanent
_____ b. The condition is temporary and he/she should be able to use the fixed route system (Santa Fe Trails Bus Service) by _____(date).
_____ c. The condition is intermittent _____% of the time and he/she will not be able to use the fixed route system (Santa Fe Trails Bus Service).

If you selected C please explain you answer

3. If the person has a disability affecting mobility, is the person:

Able to walk one city block without the assistance of another person?

_____ Yes _____ No _____ Sometimes

Able to travel 5 city blocks without the assistance of another person?

_____ Yes _____ No _____ Sometimes

Able to climb three 12-inch steps without assistance?

_____ Yes _____ No _____ Sometimes

Able to wait outside without support for ten minutes?

_____ Yes _____ No _____ Sometimes

Does this person use any mobility aids? If so what?

Does this person require a private care attendant when traveling public transportation (Santa Fe Ride)?

_____ Yes _____ No _____ Sometimes

4. If the person has a visual Impairment:

Visual Acuity with Best Correction:

Right eye_____ Left eye_____ Both Eyes_____

Visual fields:

Right eye_____ Left eye_____ Both Eyes_____

Can the person read 12 inch font print?_____yes_____no

5. If the person has a cognitive disability:

Is the person able to:

Give addresses and telephone number on request?

_____ No _____ Yes

Recognize a destination or landmark?

_____ No _____ Yes

Deal with unexpected situations or unexpected change in routine?

_____ No _____ Yes

Ask for, understand, and follow directions?

_____ No _____ Yes

Safely and effectively travel through crowded and/or complex facilities?

_____ No _____ Yes

6. **Please describe below in detail what the disability of your patient is and what prevents them from using the Santa Fe Trails fixed route service.**

7. **Please indicate if the applicant has a physical or a mental disability, and is there any other effect of the disability of which the City of Santa Fe should be aware?**

Physician Name (Print):_____

Office Address:_____

Office Phone Number:_____

Physician/Healthcare Professional Signature:_____Date_____

**RETURN FORM TO: TRANSIT SERVICE
P.O. BOX 909
SANTA FE, NM 87504-0909**