



## **Application for Santa Fe 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.**

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**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?

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**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?**

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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?

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**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

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**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: ALL 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.

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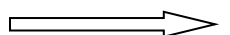
7. Please describe in detail why does the disability indicated above prevents her/him from using the Santa Fe Trails bus service and needing them to use the Santa Fe Ride Paratransit Service? (Example: Patients medical treatment(s) leaves him/her exhausted for them to walk to a bus stop.)

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Continue on back



8. 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?

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Physician Name (Print): \_\_\_\_\_

Office Address: \_\_\_\_\_

Office Phone Number: \_\_\_\_\_

Physician/Healthcare Professional Signature: \_\_\_\_\_ Date \_\_\_\_\_

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