



Greenville Area Paratransit

Greenlink's Complementary Paratransit Service

Greenlink Administrative Offices

**100 W McBee Ave
Greenville, SC 29601
864-467-2759**

Information & Application Packet

Thank you for your interest in Greenville Area Paratransit (GAP), Greenlink's complementary paratransit service. This service operates in accordance with the Americans with Disabilities Act (ADA) to provide shared ride, curb-to-curb service to individuals who cannot use Greenlink's fixed route bus service due to a disability. Please see the GAP Rider's Guide booklet for more details on our policies, fares, service area, and more.

Before You Begin

Please read all of the included material carefully before you begin to fill out your application. The information you provide will help us determine your eligibility. All pages of this application are required. Incomplete applications or applications without signatures cannot be processed and will be returned to you, possibly delaying the application process.

This application is divided into two sections: the first section, *Applicant Interview*, is to be completed by you and/or a trusted person to assist you if necessary. At the end of this section is an important statement that gives your doctor or other licensed health care professional permission to share information about your condition with us. The second section, *Professional Verification*, is to be completed only by your health care provider; you do not need to fill out anything in this section.

Completing Your Application

If you need assistance completing this application or have any questions, please contact our office at 864-467-2759. This letter and application are available in alternate formats upon request.

Please answer all questions as honestly and accurately as possible so we can best determine your eligibility. These questions help us understand your functional abilities and limitations, as well as determine the circumstances under which you may be able to use fixed route bus service and/or paratransit service.

After you have completed the first section, take this entire application to your preferred licensed health care professional's office and ask them to complete the second section, *Professional Verification*. A health care provider who is already familiar with you and your disability will be most able to complete this section accurately. Once they have completed the second section, you may submit your application to GAP.

Submitting Your Application

Before submitting your application, take a moment to review it to ensure it is complete and accurate. Remember: incomplete applications or applications without signatures cannot be processed and will be returned to you, possibly delaying the application process. You may submit your completed application by one of the methods below.

Mailing address:

Greenlink / GAP
100 W McBee Ave
Greenville, SC 29601

E-mail: wgreer@greenvillesc.gov

Fax: 864-467-5006

Once we receive your completed application, we will begin processing it and will work to make a determination of your eligibility within 21 days. You will be notified of your eligibility status in writing. If additional time is required to complete this process, you will temporarily be considered eligible until we make a determination.

Determining Eligibility

Eligibility is determined on a case-by-case basis. Individuals who are unable to travel to or from bus stops, board or exit buses, or understand how to ride and use the system may be eligible for this service.

When determining eligibility, we look at your travel destinations as well as the area around your home, including nearby bus stops, to review their accessibility based on the information you provide about your disability. In cases where you may be able to use fixed route bus service for some trips but not for others, you may be granted conditional eligibility. With conditional eligibility, GAP would be able to assist you on trips to or from locations that are not considered accessible by fixed route bus service. Regardless of eligibility, all rides will need to be scheduled between 8:00am and 5:00pm the day before you travel.

Appeal Process

If we determine you are able to use fixed route bus service, and therefore are ineligible for paratransit service, we will notify you of the reason(s) for this determination in writing. Denied applicants will then have 60 days to file a written appeal. Once we receive your appeal, we will have 30 days to review your case and make a determination about your eligibility. Eligibility appeals should be addressed to: Assistant Director of Public Transportation, 100 W McBee Ave, Greenville, SC 29601.

All decisions made by the Assistant Director are final. If a decision is not made within 30 days of receipt of your appeal, transportation will be provided until and unless a decision to deny the appeal is issued.

Expiration & Renewal

If we determine you are eligible for paratransit service, your application will be approved for a maximum of four years. To avoid a lapse in service, you must reapply before your approval expires. Please plan to submit a new completed application at least 30 days prior to expiration. If your condition is expected to be temporary, you may be approved for a shorter period covering the expected duration of your disability.

Privacy

The information you supply in this application will be kept confidential and will only be used to determine your eligibility for paratransit service. It will be retained only for the purpose of providing service to you. Access to the information you provide is limited to Greenlink administrative personnel and it is not available for public review.

Section 1 – Applicant Interview

This section of the application will help us get to know you and assess your needs when traveling. It should be completed by the person requesting service and/or a trusted individual who can answer questions on their behalf.

Part A – Contact Information

Please tell us how we can get in touch with you regarding your application and any service you may be eligible to receive.

<i>Last Name</i>	<i>First Name</i>	<i>MI</i>	<i>Date of Birth</i>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>Street Address (No PO Boxes)</i>			<i>Apt / Unit #</i>
<input type="text"/>			<input type="text"/>
<i>City</i>	<i>State</i>	<i>ZIP</i>	<i>Phone (Home/Cell)</i>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>Gender</i>	<i>Preferred Language</i>	<i>Ethnicity</i>	<i>Phone (TTD/TTY)</i>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Please include at least one emergency contact who is familiar with your disability.

<i>Emergency Contact Name</i>	<i>Phone (Day)</i>	
<input type="text"/>	<input type="text"/>	
<i>Relationship</i>	<i>Company/Agency (If Applicable)</i>	<i>Phone (Evening)</i>
<input type="text"/>	<input type="text"/>	<input type="text"/>

<i>Emergency Contact Name</i>	<i>Phone (Day)</i>	
<input type="text"/>	<input type="text"/>	
<i>Relationship</i>	<i>Company/Agency (If Applicable)</i>	<i>Phone (Evening)</i>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Part B – Nature of Your Disability

This part asks some basic, general questions about your disability.

1. **What disability (health condition, diagnosis, etc.) prevents you from using the fixed route bus service?**

2. **Is your disability permanent or temporary?**

Permanent Temporary Not sure

If you answered temporary, how long do you expect to have a disability?

3. **The disability that prevents me from using the fixed route buses would place me in the following category:**

- I am unable to ride the bus without the assistance of someone else.
 The bus stop is not accessible due to lack of sidewalks or curb cuts.
 My disability prevents me from getting to and from the bus stop.
 My disability does not prevent me from riding the bus.

4. **Please select any mobility aids you use (check all that apply):**

- | | |
|--|--|
| <input type="checkbox"/> manual wheelchair | <input type="checkbox"/> walker |
| <input type="checkbox"/> powered wheelchair | <input type="checkbox"/> cane |
| <input type="checkbox"/> large powered chair (exceeds ADA) | <input type="checkbox"/> long white cane |
| <input type="checkbox"/> power scooter/cart | <input type="checkbox"/> braces |
| <input type="checkbox"/> service animal | <input type="checkbox"/> crutches |
| <input type="checkbox"/> prosthesis | <input type="checkbox"/> communication board |
| <input type="checkbox"/> None | <input type="checkbox"/> Other: _____ |

5. **If you use a wheelchair or scooter, we need more information about it:**

Please note: the Americans with Disabilities Act (ADA) defines a common wheelchair as being no more than 30" wide by 48" long and weighing no more than 600 pounds when occupied. If your mobility device exceeds these dimensions, or if it presents a safety issue to yourself or others, the ADA cannot guarantee paratransit service even if otherwise qualified.

How wide is your wheelchair/scooter? _____ inches wide

How long is your wheelchair/scooter? _____ inches long

How much does it weigh when occupied? _____ pounds

6. Do you have limited vision?

- Yes No

If you answered yes, please explain: _____

7. Are you considered legally blind? Legally blind is defined as visual acuity in your best eye with correction is no better than 20/200, or the visual field of the best eye is constricted to less than 20 degrees.

- Yes No Not sure

Part C – Current Travel Routine

This part focuses on how you usually travel to and from your most common destinations. Using the fixed route bus service does not disqualify you.

1. Are you, in general, able to travel by yourself?

- Always Never Sometimes Not Sure

2. Do you currently use the fixed route bus service?

- Yes No Sometimes

If you answered yes or sometimes, about how many times per week? _____

3. If you currently use the fixed route bus service, do you need the help of another person to use the service?

- Yes No

If you answered yes, please tell us how they help you (check all that apply):

Get to or from the bus stop Always Sometimes

Get on or off the bus Always Sometimes

Get where I am going Always Sometimes

Other (please explain): _____

4. Have you ever had any training to learn how to use the fixed route bus?

- Yes No

If you answered yes, please tell us about your experience:

- I completed the training I learned about general bus travel
 I did not complete the training I learned about riding specific routes

If you answered no, would you like someone to contact you to discuss training on how to use the fixed route bus system?

- Yes No

5. List the five destinations you most frequently visit; include how often you go and what method you currently use to get there (e.g., car, taxi, bus, etc.).

	<i>Location Name/Address</i>	<i>How Often</i>	<i>Method</i>
a.	_____	_____	_____
b.	_____	_____	_____
c.	_____	_____	_____
d.	_____	_____	_____
e.	_____	_____	_____

6. What is the closest bus stop to your home?

7. Can you get to this bus stop by yourself?

- Yes No Sometimes

If you answered no or sometimes, please explain: _____

8. How would you describe the terrain (surface of the ground) where you live (e.g., steep, level, hilly, gravel, paved, etc.)?

Part D – Functional Abilities & Limitations

This part tells us about some of the things you can or cannot do when traveling and what kind of assistance you might need.

1. **Please explain how your disability prevents you from using the fixed route bus system. Please be specific and attach separate sheets if necessary.**

2. **With or without a mobility aid, how far are you able to travel without assistance from another person?**

- Less than 200 feet About 1/2 mile (6 blocks)
 About 1/4 mile (3 blocks) About 3/4 mile (9 blocks)

3. **Are you able to wait outside without support for up to 15 minutes?**

- Yes No Sometimes

4. **How long are you able to wait at a bus stop?**

Up to _____ minutes.

5. **Are you able to grip a handrail to support yourself?**

- Yes No Sometimes

6. **Can you walk up and down three steps up to 12" tall if there are handrails on both sides?**

- Yes No Sometimes Not Sure

7. **Can you travel one level block on the sidewalk if the weather is good?**

- Yes No Sometimes Not Sure

8. **Do changes in the weather (extreme heat, cold, wind, rain, snow, or ice) prevent you from getting around on your own?**

- Yes No

If you answered yes, please explain: _____

9. Does weather affect your ability to use Greenlink fixed route bus service?

- Yes No

If you answered yes, please explain: _____

10. About how many blocks do you need to travel to get to the nearest bus stop?

- Less than 2 blocks 4 or more blocks
 2-4 blocks Not sure

11. Are you able to maneuver onto or off a wheelchair ramp without assistance?

- Yes No Not sure

12. Are you prevented from traveling to or from a boarding location for one or more of the following reasons? Check all that apply:

- Inability to negotiate hilly terrain Night blindness
 Allergies/environmental sensitivities Hyper-fatigue, frailty
 Inability to cross busy intersections Extremely sensitive to climate
 Other: _____

13. Can you communicate with the vehicle operator by yourself or with the help of an aid such as a letter board?

- Yes No

14. Are you able to give addresses and telephone numbers upon request?

- Yes No

If you answered no, please explain: _____

Continue to Part E – Personal Care Attendant Certification on the next page.

Part E – Personal Care Attendant Certification

A Personal Care Attendant (PCA) is someone designated or employed specifically to assist you with completion of at least one daily activity on a regular basis. Please initial only one of the statements below:

_____ I certify that I need the services of a Personal Care Attendant to make independent travel possible. I will need a PCA to travel with me on the following basis:

- Permanently Occasionally Temporarily

If you answered temporarily, what is the expected duration of your need for a PCA? _____

_____ I certify I do not need the services of a Personal Care Attendant at this time. If this changes in the future, I will communicate this change to GAP.

Continue to Part F – Authorization & Signature on the next page.

Part F – Authorization & Signature

By signing below, I agree to the terms and conditions described in this application, certify all information provided is correct, and acknowledge providing false or misleading information could result in my eligibility being denied or revoked. I understand this information will be used only for determining my eligibility for complementary paratransit service.

Additionally, I hereby authorize the licensed health care professional completing *Section 2 – Professional Verification* of this application to release information regarding my disability contained within that section to Greenlink. I understand I may revoke this authorization at any time. Unless revoked, this form will allow the licensed health care professional completing *Section 2* to release the information described for up to six months after the date below.

Applicant Signature

Date

Parent / Legal Guardian Signature (If Applicant Is Under 18)

Date

If someone other than the applicant completed any part of *Section 1* of this application, please complete the line below:

Signature

Relationship to Applicant

Date

STOP

End of Section 1 – Applicant Interview

Do not continue filling out the remainder of this application yourself; please take it to your preferred health care professional who is familiar with your disability. Ask them to complete Section 2 – Professional Verification and return it to you.

Section 2 – Professional Verification

This section of the application helps us to verify the answers completed in *Section 1 – Applicant Interview*. It should be completed only by a licensed health care professional and/or their staff.

About This Application

You are being asked by the individual named in *Section 1* of this application to provide information regarding their ability to use fixed route bus service provided by the City of Greenville / Greenlink. Fixed route bus service typically consists of buses designed to carry a number of people while operating along predetermined routes and serving passengers waiting at designated stops on a set schedule.

Persons who are unable to use fixed route bus service with the accommodations provided may be eligible to use Greenville Area Paratransit (GAP), the complementary curb-to-curb paratransit service offered by Greenlink. The information you provide in this application will allow us to evaluate the applicant's request and determine their specific needs.

Please note: the Americans with Disabilities Act (ADA) requires public transit agencies to provide paratransit service to people whose disabilities prevent them from using a bus some or all of the time. Disability, distance to or from a bus stop, inconvenience, and decreased comfort are not, by themselves, considered to be a basis for qualification. The applicant's condition must prevent travel by bus.

The information you provide will enable us to make an appropriate determination for this applicant. All information you provide will be kept confidential and accessible only by Greenlink staff for the purpose of determining eligibility and providing service to the applicant.

Thank you for your assistance.

Instructions to Health Care Professional

Please follow these steps to verify the information provided in this application:

1. Read the applicant's responses to the questions in *Section 1* of this application.
2. Fill out this section as completely as possible based on your knowledge of the applicant's disability.
3. Maintain a copy of this application for your records; *Part F – Authorization & Signature* contains an authorization for release of information to Greenlink / Greenville Area Paratransit. In the event we need to contact you for further information, this release will permit your staff to provide such information.
4. Return this completed application to the applicant within 7 days of receipt; the applicant will be responsible for returning the application to Greenlink.
5. Contact us if you have any questions by calling our office at 864-467-2759.

Continue to the verification questions on the next page.

Verification Questions

Please answer the following questions as completely and accurate as possible to help us better understand the applicant's disability.

1. In what capacity do you know this individual?

2. How long have you known or been treating this individual? _____

3. What was the last date of face-to-face contact, by you or your agency, with this individual?

4. Based on your knowledge of the applicant's condition, is the information provided in *Section 1* a reasonable representation of their condition?

Yes No

If you answered no, please explain: _____

5. Please describe the applicant's disability and diagnosis:

6. Does the applicant's disability prevent them from using current bus system?

Yes No

If you answered yes, please explain: _____

7. How does the disability affect the applicant's mobility?

8. Specify which functional limitations are associated with this applicant's condition:

- Mobility impairment Cognitive impairment
 Visual impairment Hearing impairment
 Compromised endurance (muscular / respiratory)

9. Does the applicant have any other medical condition of which GAP should be aware?

- Yes No

If you answered yes, please explain: _____

10. What is the expected duration of the applicant's condition?

- Permanent Long Term Temporary until: _____

11. Please select any mobility aids the applicant may use (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> manual wheelchair | <input type="checkbox"/> walker |
| <input type="checkbox"/> powered wheelchair | <input type="checkbox"/> cane |
| <input type="checkbox"/> extra-large wheelchair | <input type="checkbox"/> long white cane |
| <input type="checkbox"/> power scooter/cart | <input type="checkbox"/> braces |
| <input type="checkbox"/> service animal | <input type="checkbox"/> crutches |
| <input type="checkbox"/> prosthesis | <input type="checkbox"/> communication board |
| <input type="checkbox"/> None | <input type="checkbox"/> Other: _____ |

12. How far can the applicant travel using a mobility aid?

- Cannot travel up to 300 feet
 Can travel up to 300 feet (one football field)
 Can travel up to 500 feet (one city block)
 Can travel up to 600 feet (two football fields)
 Can travel up to 1,320 feet (one lap around a track)

13. Does the disability prevent the applicant from getting to or from a bus stop?

- Yes No Sometimes

If you answered yes or sometimes, please explain: _____

14. Can the applicant climb a 12" step?

- Yes No Sometimes

If you answered sometimes, please explain: _____

15. Does the applicant's disability prevent them from waiting at a bus stop?

- Yes No

16. How long could the applicant wait if sitting / standing / using mobility device? _____ minutes

17. Does the disability prevent the applicant from riding a wheelchair accessible bus?

- Yes No Sometimes

If you answered yes or sometimes, please explain: _____

18. Does the weather affect the applicant's ability to travel?

- Yes No Sometimes

If you answered sometimes, please explain: _____

19. Does the applicant have a medically defined sensitivity to heat or cold?

- Yes No

If you answered yes, please specify the condition: _____

If you answered yes, please specify above/below this temperature: _____

20. Does the applicant require a Personal Care Attendant (PCA) when traveling?

A Personal Care Attendant is not a companion or escort, but someone who is employed or otherwise designated to provide the applicant with assistance for mobility, personal care, communication, transportation, sign language interpretation, reader services, etc. as the applicant makes their trip.

- Yes No Sometimes

21. Are any of the following affected by the applicant's disability? Check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Monitoring time |
| <input type="checkbox"/> Problem-solving | <input type="checkbox"/> Judgment |
| <input type="checkbox"/> Short-term memory | <input type="checkbox"/> Communication |
| <input type="checkbox"/> Long-term memory | <input type="checkbox"/> Inconsistent performance |
| <input type="checkbox"/> Concentration | <input type="checkbox"/> Coping skills |
| <input type="checkbox"/> Gait or balance | <input type="checkbox"/> Inappropriate social behavior (check all that apply): |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> aggressive <input type="checkbox"/> sexual <input type="checkbox"/> over-friendly |

Please explain how the above interferes with safe community travel: _____

22. Describe how the applicant's disability affects their ability to complete the following tasks:

Traveling alone outside: _____

Leaving home on time: _____

Seeking and acting on directions: _____

Finding way to/from bus stop: _____

Crossing streets: _____

Waiting for the bus: _____

Riding on the bus: _____

Monitoring time: _____

Transferring to a second bus or exiting at correct destination: _____

23. Would “ride training” be appropriate for this individual?

- Yes No

If you answered no, please explain: _____

24. Are there any life skills this individual lacks which would be an indication of their inability to use public transportation?

- Yes No

If you answered yes, please explain: _____

25. Is the goal of traveling independently (even limited travel in the neighborhood) within the scope of treatment?

- Yes No

26. Can the applicant wait outside for up to 15 minutes?

- Yes No

Continue to the professional verification statement & signature on the next page.

Verification Statement & Signature

Please complete the following section. Select the options that best represent your field and professional opinion regarding the applicant’s eligibility, then sign and date at the end.

_____			_____
<i>Name of Health Care Professional (Print)</i>			<i>License Number & State</i>
_____			- -
<i>Street Address</i>			<i>Telephone</i>
_____	_____	_____	- -
<i>City</i>	<i>State</i>	<i>ZIP</i>	<i>Fax</i>

Select professional type (initial one):

_____ Physician	Specialty: _____
_____ Physician’s Assistant	_____ Nurse / Nurse Practitioner
_____ Mental Health Counselor	_____ Optometrist / Ophthalmologist
_____ Licensed Clinical Psychologist	_____ Certified School Psychologist
_____ Respiratory Therapist	_____ Occupational Therapist
_____ Physical Therapist	_____ Rehabilitation Specialist
_____ Other: _____	

Based on the information supplied in this application, do you believe, in your professional opinion, the applicant herein qualifies for complementary paratransit service due to a qualifying disability? Please initial in the appropriate blank below.

_____ Yes, in my professional opinion the applicant qualifies according to the guidelines herein.

_____ No, in my professional opinion the applicant does not qualify according to the guidelines herein.

_____	_____/_____/_____
<i>Health Care Professional Signature</i>	<i>Date</i>

End of Section 2 – Professional Verification

Thank you for taking the time to complete this form on behalf of the applicant. Please make a copy for your records and return the original application to the applicant within 7 days.