



Please provide the name and phone number of a LOCAL friend or relative to contact in the event of an emergency:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

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

- |  |  |
|--|--|
| <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Electric Wheelchair |
| <input type="checkbox"/> Power Scooter     | <input type="checkbox"/> Cane                |
| <input type="checkbox"/> Crutches          | <input type="checkbox"/> Walker              |
| <input type="checkbox"/> Oxygen Tank       | <input type="checkbox"/> Service Animal      |
| <input type="checkbox"/> Other _____       | <input type="checkbox"/> None                |

2. Is your mobility device oversized?  Yes  No

a. If yes, please explain: \_\_\_\_\_

b. Does your mobility device weigh less than 600 pounds when occupied?

- Yes  No

3. Is your condition temporary?  Yes  No

If yes, expected duration: \_\_\_\_/\_\_\_\_/\_\_\_\_

4. Does your condition change from time to time due to medications, medical treatments, other?  Yes  No

If yes, please explain

\_\_\_\_\_

\_\_\_\_\_

**Type of disability:**

5. I have a  **Visual**  **Physical**  **Mental** Impairment

6. **What** is your disability and **how** does it make it **impossible** for you to use the fixed route service?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. How far can you continuously walk **OR** advance your manual wheelchair without the help of another person? (i.e., number of blocks) \_\_\_\_\_

Could you travel further if you stopped to rest?

- Yes       No       Sometimes

(If No or Sometimes, please explain why)

---

---

8. Have you ever used any of these transit services? Check all that apply:

- Fixed Route    Paratransit    RTD Hopper    Other \_\_\_\_\_

9. How many blocks from your residence is the nearest accessible bus stop?

- Less than 1 Block    2 to 4 Blocks    4 or more    Don't know

10. Can you independently get on and off a lift-equipped bus?

- Yes       No       Sometimes       Don't know

(If No or Sometimes, please explain why)

---

---

11. Would your ability to use public transit be affected by weather or environmental/architectural barriers that block your path of travel? (e.g. temperature extremes, no sidewalks, lack of signal lights at a busy intersection, etc.)

- Yes    No   (If Yes, please explain why)

---

---

---

12. Can you ask for, understand, and follow directions?

- Yes       No       Sometimes

(If No or Sometimes, please explain why)

---

---

13. Can you cross a busy intersection?

- Yes       No       Sometimes

(If No or Sometimes, please explain why)

---

---

14. If you are approved for Paratransit Services will you require a personal care attendant?

Yes

No

### **Certification of Applicant**

I hereby certify that, to the best of my knowledge, the information I have given in this application is correct and the application will be returned if it is not complete.

I understand that the results of the review will be based on my ability to use the fixed route system. Verification of my disability by my physician or health care professional, identified below, does not guarantee my eligibility for ADA certification of paratransit service.

**Signature of Applicant** \_\_\_\_\_

**Date** \_\_\_\_\_

*If someone other than the applicant completed this application, the following information must be provided.*

Name of person completing the application \_\_\_\_\_

Relation to the applicant \_\_\_\_\_

Daytime phone # \_\_\_\_\_