LHC DIRECT Paratransit Service Application

Pursuant to the requirements of the Americans with Disabilities Act of 1990, Paratransit service is a shared-ride public transportation service offered to customers as an alternative transport service for those with accessibility needs. It's a flexible and customized transit experience available to members of the community who are unable to utilize public transport services. Paratransit service is offered to seniors 60+ and disabled who need to schedule their trips to meet appointment or other obligations.

Provided with this letter is the application for paratransit service, along with the mandatory health care provider verification form, as well as customer guidelines and policies. A health care verification form is provided on Page 4 of this packet. All passengers seeking Paratransit service are required to visit a licensed health care professional to document the presence of a disability and a description of how Paratransit service is provided only to those passengers who have a confirmed disability that prevents their use of public transport services.

Passengers approved for the service will be added to the paratransit rider listing. Paratransit eligibility expires three years from the date of approval. Recertification of eligibility will be required upon expiration. The three year approval timeframe includes passengers categorized as having a permanent disability.

Once eligibility is granted, passengers may schedule rides through the Lake Havasu City Transit Office. Transit personnel are available 9:00 am through 4:00 pm Monday through Friday. Passengers may schedule rides up to seven days in advance. Please remember that paratransit is a shared ride service.*

Please refer to the Paratransit Guideline on the Lake Havasu City Transit website at www.lhctransit.org or call 928-453-7600 to receive a mailed copy.

***SHARED RIDE SERVICE:** Shared ride services take customers from one location, such as their home, to their destination. Trips are scheduled in advance, and vehicles are shared by multiple riders. Shared ride service is accessible by people using a wheelchair or other mobility device.

After completing the application, please retain pages 5 & 6 for your reference, and ***return pages 2, 3 & 4*** to: **Lake Havasu City Transit, 900 London Bridge Road, Bldg. B, Lake Havasu City, AZ 86404**

Lake Havasu City Transit
Paratransit Service Application

Received applications will be processed within a period of 21 days or less and all applicants will be notified of their eligibility with a letter sent via U.S. mail. If you have any questions about the Lake Havasu Paratransit service please call (928) 453-7600.

Paratransit service is intended for those who have a mobility limitation resulting from a functional or cognitive disability that prevents the reasonable use of general public transit. Disability is not an automatic qualifying determinant for ADA Paratransit bus service; a mobility limitation must be present.

Name_____
LAST FIRST

Date of Birth_____

Street Address_____

City_____ State_____ ZIP_____

Mailing address (if different from above)_____

Email address _____

Daytime phone number _____ Please check if this is a TDD line [ ]

Cell phone number_____ Please check if this is a TDD line [ ]

Emergency contact information:

Name_____

Relationship_____

Daytime phone _____ Cell Phone _____

Mobility Aids: Will you use any of the following when you use paratransit service?

Please check that all apply:

☐ manual wheelchair ☐ power wheelchair ☐ power scooter ☐ cane/crutches

☐ white cane ☐ walker ☐ portable oxygen

☐ other _____

Do you travel at times with a Personal Care Attendant (PCA) or Caregiver?

☐ YES ☐ NO

Do you use a service animal?

☐ YES ☐ NO

If so, please describe what type of animal and for what specific purpose it was trained.

_____

Please note: *Service animals must be kept under the control of their owner at all times. If the animal acts out of control or causes a major disturbance, the animal may be removed from the Transit vehicle.*

Is your disability: ☐ Permanent ☐ Temporary

If temporary, I expect it to last until _____

PLEASE NOTE:

- Passengers using wheelchairs or other mobility aids exceeding the design capacity of the vehicle's securement areas may be transported at the driver's discretion. Service will be declined if safety or vehicle integrity is compromised.
- Oxygen tanks must be in a portable carrier.
- A passenger needing to travel with a Personal Care Attendant (PCA) or Caregiver is instructed to indicate that need during this registration process. Unless the need for a PCA/Caregiver is indicated on the application, any accompanying the medically qualified individual on trips will be considered a companion.

I hereby certify that, to the best of my knowledge, the information given in this application is correct and I authorize the health care professional identified to provide additional information to Lake Havasu City Transit regarding my general mobility.

Signature of Applicant_____ Date_____

If someone other than the Applicant completed this application, the following information must be provided:

Name of person completing application (Please Print)_____

Relation to applicant_____ Phone Number_____

Health Care Professional Certification Medically Qualified Verification Form

Important Instructions for Healthcare Providers

As a requirement of the Americans with Disabilities Act of 1990, Lake Havasu City Transit Paratransit is a federally subsidized public transportation service set aside for passengers who are prevented from using general public transit service due to a mobility limitation. Disability alone is not an automatic qualifying determinant for ADA Paratransit service. As a medical provider, you are uniquely familiar with the general health and abilities of your patient. As such, please provide answers to the following questions as they relate to mobility limitations resulting from a functional or cognitive disability.

Disability verification for _____
PATIENT NAME

1. Does the applicant have a mobility limitation due to a functional or cognitive disability that is permanent or temporary in nature? ☐ Yes ☐ No

_____

_____

I hereby certify this information to be true and correct to the best of my knowledge.

Signature _____ Date _____

Health Care Professional Printed Name _____

Health Care Professional License Number _____

Address _____

City _____ State _____ ZIP _____

Phone _____