5310 Eligibility Application

1. **Name:** ____

2. **Address:** ____

3. **Telephone #:** ____________________ **Alternative #:** ____________________

   Email Address: ____

4. **Date of Birth:** ____________________

5. **Emergency Contact Information**

   Name: ____

   Telephone #: ____________________ **Relationship**: ____________________

6. **Do you use a mobility device?** ☐ Yes ☐ No

   Please mark all that apply:

   ☐ Portable Oxygen
   ☐ White Cane
   ☐ Wheelchair / Powered
   ☐ Wheelchair / Manual
   ☐ Respirator
   ☐ Crutches
   ☐ Service Animal
   ☐ Power Scooter
   ☐ Walking Cane
   ☐ Other, please explain: ____________________
   ☐ Walker
   ☐ Leg Braces
   ☐ Prosthesis
   ☐ Communication Board

7. **Is there public transportation available within ¼ mile of your residence?** ☐ Yes ☐ No

   a. **If yes, do you have the ability to use the public transportation vehicle equipped with a ramp/ lift?** ☐Yes ☐ No

      If no, please explain:____

      ____

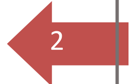
8. **Without assistance, are you able to travel without difficulty to the nearest public transportation bus stop?**

   ☐ Yes ☐ No ☐ Sometimes explain, ______________________________

9. **Is your disability or disabilities a permanent or temporary condition?**

   ☐ Permanent ☐ Temporary

5310 Eligibility Application



10. **Do you require a Personal Care Attendant?**

    ☐ Yes ☐ No

11. **Are you able to locate landmarks of your destination without assistance?**

    ☐ Yes ☐ No ☐ Sometimes

12. **Please use this space to tell us anything else you would like us to know about travel challenges and your ability to use transportation service:**____

    ____
    ____
    ____
    ____

13. I certify all information is true and correct. I agree that if any information is given to Project Amistad (PA) is false and misleading, PA will have the right to reconsider my right to participate in the 5310 Transportation for Enhanced Mobility for Seniors and Persons with Disabilities. I understand that I may be asked for an in-person interview to verify the information provided is correct. If asked to come in, PA will provide transportation.

    IMPORTANT: PA will only use this information to determine the eligibility to use the agency's transportation program. PA will keep this information confidential and secure and will only use it for transportation-related purposes. PA may also use the contact information provided to solicit feedback about the transportation program, including providing the telephone and name to a third-party to carry-out periodic surveys.

Signature_________________________________ **Date:** _____________________________

For PA use only

☐ **Approved-** I have reviewed the 5310 Application and confirm that the information provided in this form is true and correct. I have reviewed all supporting documentation and agree that the client is eligible to use transportation services.

☐ **Denied**-I have reviewed the 5310 Application and confirm that the information provided in this form is true and correct. I have reviewed all supporting documentation and agree that the client is not eligible to use transportation services.

Reason for denial:____

Reviewed by:__________________________ Signature: ______________________________ Date:___________________

(Print Name)

Client's Rights and Responsibilities
Enhanced Mobility for Seniors and Persons with Disabilities
(5310 Program)

Client Name: ____Date: ____________________

Purpose:

Project Amistad's (PA) 5310 Program provides curb-to-curb transportation services to elderly and persons with disabilities, whose point of origin is within the city limit or outside the city limit within the County of El Paso. The purpose of this program is to provide transportation services, virtually for any reason, once approved by PA.

Procedures:

- **Approved trips:** Only approved trips will be scheduled by PA. If you have other transportation needs, you must contact PA for approval. PA schedules and provides trips on a first come first serve basis. The number of trips scheduled per month will vary, depending on the funding availability.
- **Exceptions:** PA will not allow exceptions to the procedures. Under extenuating circumstances, PA management will review an exception request and approve on a case-by-case basis.
- **Scheduling a trip**: All trips must be scheduled at least **two** working days in advance (8 AM – 4 PM) and by calling (915) 532-3415. PA will schedule trips Monday thru Friday. Unscheduled trip will not be authorized. PA does not operate on Sundays.
- **Cancellation**: Cancellations should be made 24 hours in advance. However, clients are encouraged to call PA with a cancellation with as much notice as possible.
- **Change in service**: If your conditions or transportation needs change, you must contact the office for appropriate changes. Call (915) 532-3415.
- **Service**: The client is expected to be ready **one** hour before the appointment if the client lives within the city limits and **two** hours before the appointment if the client lives outside the city limits, but within the El Paso County. PA drivers will wait up to 5 minutes. After a 5-minute wait, the driver will leave. In this case the trip will be recorded as a no-show.
- **Fare**: All clients are required to pay $ 3.00 per each one-way trip.

Suspension of Services:

- **Behaviors:** The safety and comfort of our passengers is our first priority. Clients are expected to treat PA drivers and other passengers with respect and dignity.
- **No show**: Clients will be susceptible to termination of service after **two** sequence no shows in **one month** or consistently being late.

Rights: You have the right to ask for and receive a Fair Hearing if services available by PA are denied. Your records are protected under Texas State Law and cannot be disclosed without your written consent. Your information may be shared among members of the Transportation team, including schedulers, dispatchers and field supervisors, without written consent for staffing purposes. The law requires the release of confidential information in three other situations: suspected abuse of child, dependent adult or developmentally disabled person; potential suicidal behavior or harm to self; or the contemplation or commission of a harmful act(s) toward another person(s).

Signatures:

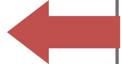
I have read and understood the above rights and responsibilities. I agree to follow these procedures and I understand that failure to follow the rights and responsibilities can result in the suspension or termination of service.

Client Signature: ____ Date: _____________________

PA Signature: ____ Date: _____________________

Enhanced Mobility for Seniors and Persons with Disabilities
5310 Program
Eligibility Determination

Please have your doctor or a certified agency complete and sign this form.



Applicant's Name: ____

Applicant's Date of Birth: ____

Dear Doctor/Agency:

Amistad provides curb-to-curb transportation service on a shared-ride system using vehicles equipped with hydraulic wheelchair lifts. This service is available to seniors and persons with disabilities who are unable to:

- **Independently travel to/from a bus stop using traditional fixed-route buses**
- **Independently board, ride and exit a public transportation fixed-route bus**
- **Board or travel to/from a bus stop because of the inability of the bus to deploy the lift or ramp at an inaccessible bus stop**

The above applicant is applying for the 5310 Transportation Program—Enhanced Mobility for Seniors and Persons with Disabilities and is kindly requesting information regarding his/her disability. This information will allow Amistad to properly evaluation the applicant's inability to ride the El Paso City/County transit traditional fixed-route system and thereby becoming eligible for Amistad paratransit system. *Thank you for your cooperation.*

Eligibility Determination form must be filled out completely to be approved.

1. Capacity in which you know the applicant: ____
2. Condition causing the disability: ____
3. Is the condition temporary? Yes ☐ No ☐
   a. If yes, what is the expected duration? _____________________________________
4. If the person has a disability affecting mobility, is the person able to travel without assistance?
   Yes ☐ No ☐ Sometimes ☐ explain: ______________________________
   ____
   ____
5. Does the person use any mobility aids? Yes ☐ No ☐
   a. If yes, describe: ____
   ____

Enhanced Mobility for Seniors and Persons with Disabilities
5310 Program
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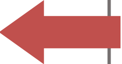

6. Does the applicant have a visual impairment? Yes ☐ No ☐
   (e.g., peripheral vision, macular degeneration, cataracts, etc.)
   Right eye ________ Left eye ________ Both eyes ________
   If other vision condition, please describe: ____
   ____

7. **Does the applicant have an intellectual disability? Yes ☐ No ☐**
   If yes, please describe: ____
   ____
   ____

8. **Are there any other conditions or disabilities that would prevent this applicant from riding the traditional wheelchair-accessible fixed route that Amistad should be aware of?**_____________
   ____
   ____
   ____
   ____

I certify that the information provided is true and correct to the best of my knowledge.
Agency or Physician's Name: ____
Address: ____
Phone Number: ____
Signature: ____Date: ___________________________
Print Name: ____