



## **Application for GoApex Door to Door Complementary ADA Paratransit Service**

GoApex Door to Door is a shared ride service for persons with disabilities that prevent them from using GoApex fixed route service. This service will be provided by GoWake Access.

Interested individuals must complete an eligibility application and receive approval from GoWake Access before reservations will be accepted.

### **Instructions**

Applicants should complete and sign parts A and B of the application. A qualified human services or medical professional with knowledge of your disability must then complete Part C. The fully completed, signed application must then be submitted to GoWake Access for review.

Once your completed application is received it will be reviewed for eligibility. You will be notified in writing of the determination of eligibility within 21 days by GoWake Access. If eligibility is not determined within 21 days of receipt of a completed application, the applicant will be treated as eligible and provided service until a final eligibility determination is made.

Submit your application by Mail to:

GoWake Access  
Attn: GoApex ADA Eligibility Intake  
4401 Bland Rd  
Raleigh, NC 27609

OR, Submit your application by Email to:  
[TransportationADAApplications@wake.gov](mailto:TransportationADAApplications@wake.gov)

Version Effective September 2023

## Application

Please complete Parts A and B, then have a medical professional with knowledge of your disability complete Part C. This application will not be reviewed for eligibility until all three parts have been completed.

Date of Application: \_\_\_\_\_

### Part A. General Information (please complete all fields)

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Physical Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

**Note:** By providing your email address, you agree to receive email communication from GoWake Access and/or The Town of Apex. If you subscribe to the email service option, your email address will not be given to third parties in accordance with state law. We will only use the email to: (1) communicate with you about GoApex matters; (2) share emergency information with you; and/or (3) contact you regarding any email subscriber administrative issues that may arise. For questions, please call (919) 249-1043 or (919) 212-7005.

**Part A, Continued:**

Emergency Contact Information

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

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Are you:

Deaf / Hard of Hearing \_\_\_\_\_ Yes

Dial 711? \_\_\_\_\_ Yes

\_\_\_\_\_ No

\_\_\_\_\_ No

**Part A, Continued:**

Do you require any of the following? (check all that apply)

- Manual Wheelchair \_\_\_\_\_ Yes \_\_\_\_\_ No
- Power Wheelchair \_\_\_\_\_ Yes \_\_\_\_\_ No
- Motorized Scooter \_\_\_\_\_ Yes \_\_\_\_\_ No
- Cane \_\_\_\_\_ Yes \_\_\_\_\_ No
- Walker \_\_\_\_\_ Yes \_\_\_\_\_ No
- Crutches \_\_\_\_\_ Yes \_\_\_\_\_ No
- Braces \_\_\_\_\_ Yes \_\_\_\_\_ No
- Service Animal \_\_\_\_\_ Yes \_\_\_\_\_ No
- Oxygen \_\_\_\_\_ Yes \_\_\_\_\_ No

Other (please explain):

If you use a wheelchair or scooter:

What is the combined weight (\_\_\_\_\_ lbs) of the passenger and the wheelchair/scooter?

What is the length (\_\_\_\_\_ inches) and width (\_\_\_\_\_ inches) of the wheelchair/scooter?

Is your home equipped with a wheelchair ramp? \_\_\_\_\_ Yes \_\_\_\_\_ No

**IMPORTANT NOTE:** Passengers who use wheelchairs/scooters must have a ramp if steps are present. Driver's will not "bump" passengers up/down stairs or in/out of houses/buildings. Lastly, please be aware that the lift capacity is 750lbs.

I understand that the purpose of the application is to determine if I am eligible for GoApex's Door to Door transportation service. I certify that the information provided in this application is true and correct to the best of my knowledge and that the application will be returned to me if it is not complete, which delays processing. I understand that falsification or misrepresentation of facts, or changes in my medical condition, may result in changes to my certification status. I further understand that additional information from my healthcare professional related to my disability or medical condition may be required for ADA complementary paratransit service and will be used to help determine my eligibility. I agree to notify GoWake Access if I no longer need to use the GoApex Door to Door service.

**Signature of Applicant:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Applicants must be 18 years of age to sign independently. Otherwise, the signature of a guardian is required.)

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

**Printed Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Daytime Telephone Number:** \_\_\_\_\_

**Relationship to Applicant:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Applicant Name \_\_\_\_\_

**Part B. Disabling Condition and Certification**

1. What is the disability or health condition that prevents you from using GoApex’s fixed route buses? (Please be specific but use layman’s terms).

2. How does this disability or health condition limit or prevent you from using GoApex’s fixed route service? Please be specific.

3. Are the conditions you described:

\_\_\_\_\_ Permanent      \_\_\_\_\_ Vary day to day      \_\_\_\_\_ Temporary

If Temporary, what is the anticipated end date? \_\_\_\_\_

4. Do you have medically defined cold sensitivity?      \_\_\_\_\_ Yes      \_\_\_\_\_ No

Above or below what temperatures? \_\_\_\_\_

If Yes, please explain: \_\_\_\_\_

5. Do you have medically defined heat sensitivity?      \_\_\_\_\_ Yes      \_\_\_\_\_ No

Above or below what temperatures? \_\_\_\_\_

If Yes, please explain: \_\_\_\_\_

**Part B, Continued:**

6. Do other weather conditions affect your disability? \_\_\_\_\_ Yes \_\_\_\_\_ No

If Yes, please explain:

7. Do you have a visual impairment? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Sometimes

If Yes or Sometimes, please explain:

8. Is your breathing affected by weather or environmental conditions?  
\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Sometimes

If Yes or Sometimes, please explain:

9. Are any of the following skills affected by your disability?

**If the answer is Sometimes, Never, or Not Sure, please explain by describing the effect and the extent of limitation caused by the disability.**

Applicant can:

a) Cross a street with \_\_\_\_\_ 2-3 lanes \_\_\_\_\_ 4-6 lanes \_\_\_\_\_ Never

Comments: \_\_\_\_\_

b) Step on/off curbs \_\_\_\_\_ Always \_\_\_\_\_ Sometimes \_\_\_\_\_ Never \_\_\_\_\_ Not Sure

Comments: \_\_\_\_\_

**Part B, Continued:**

c) Stand on a moving bus holding onto a handrail

\_\_\_ Always \_\_\_ Sometimes \_\_\_ Never \_\_\_ Not Sure

If sometimes, how long (in minutes)? \_\_\_\_\_

Comments: \_\_\_\_\_

d) Find my own way to the bus stop without assistance

\_\_\_ Always \_\_\_ Sometimes \_\_\_ Never \_\_\_ Not Sure

Comments: \_\_\_\_\_

e) Find my own way to the bus stop if I receive training

\_\_\_ Always \_\_\_ Sometimes \_\_\_ Never \_\_\_ Not Sure

Comments: \_\_\_\_\_

f) Travel alone outside the house

\_\_\_ Always \_\_\_ Sometimes \_\_\_ Never \_\_\_ Not Sure

Comments: \_\_\_\_\_

g) Leave the house on time

\_\_\_ Always \_\_\_ Sometimes \_\_\_ Never \_\_\_ Not Sure

Comments: \_\_\_\_\_

**Part B, Continued:**

h) Seek and act on directions

Always  Sometimes  Never  Not Sure

Comments: \_\_\_\_\_

i) Safely and independently travel  $\frac{1}{4}$  of a mile (4 blocks) without help from another person

Always  Sometimes  Never  Not Sure

Comments: \_\_\_\_\_

j) Wait at a bus stop  Always  Sometimes  Never  Not Sure

If sometimes, how long (in minutes)? \_\_\_\_\_

Comments: \_\_\_\_\_

k) Board the correct bus  Always  Sometimes  Never  Not Sure

Comments: \_\_\_\_\_

l) Transfer from one bus to another

Always  Sometimes  Never  Not Sure

Comments: \_\_\_\_\_

m) Exit at the correct destination

Always  Sometimes  Never  Not Sure

Comments: \_\_\_\_\_

**Part B, Continued:**

n) Tell/monitor time      \_\_\_ Always \_\_\_ Sometimes \_\_\_ Never \_\_\_ Not Sure

Comments: \_\_\_\_\_

o) Walk on hills/steep terrain

\_\_\_ Always \_\_\_ Sometimes \_\_\_ Never \_\_\_ Not Sure

Comments: \_\_\_\_\_

p) Deal with unexpected situations

\_\_\_ Always \_\_\_ Sometimes \_\_\_ Never \_\_\_ Not Sure

Comments: \_\_\_\_\_

10. If GoApex offered free training on how to ride the fixed route buses, would you be interested?

\_\_\_ Yes \_\_\_ No

If No, please explain: \_\_\_\_\_

\_\_\_\_\_

11. ~~Do~~ you require a Personal Care Attendant (PCA) to assist with travel? A PCA is any individual who assists you with carrying out your life activities and is different than a guest or companion. Your PCA may accompany you at no additional charge.

\_\_\_ Yes, Sometimes      \_\_\_ Yes, Always      \_\_\_ No

12. ~~How~~ far can you walk/travel by yourself or with the assistance of a mobility aid (choose one of the options below and fill in a number beside it)?

\_\_\_ Feet      \_\_\_ Blocks      \_\_\_ Miles

Applicant Name \_\_\_\_\_

**Authorization for Release of Information**

I authorize the professional who has completed part C of this application to release to GoWake Access, information about my disability or health condition and its effect on my ability to travel on the GoApex fixed route service. I understand that I may revoke this authorization at any time.

I, the applicant, understand that the purpose of this application is to determine my eligibility to use the GoApex Door to Door services. I agree to release the information requested to GoWake Access and any eligibility review panel and understand that the information contained herein will be treated confidentially, unless otherwise required by law. I understand further that GoWake Access reserves the right to request additional information at its discretion. I agree to notify GoWake Access of any changes in the status of my disability that affects my ability to use the GoApex Door to Door services. I also understand that this may affect my eligibility as a rider.

**C. Health Care Provider Verification**

**Signature of Applicant:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Applicants must be 18 years of age to sign independently. Otherwise, the signature of a guardian is required.)

Dear Verifying Professional:

You are being asked by the applicant named in Part A of this application to provide information regarding their ability to use the public transportation services of GoApex, as described in Part B. GoApex provides transportation services to eligible persons with disabilities who cannot use regular fixed route bus services. The information you provide

will allow us to evaluate the request and determine the individual's specific needs. Thank you for your cooperation in this matter.

**PLEASE NOTE:** The GoApex fixed route bus service available within the Town of Apex is accessible to persons with disabilities.

The individual applying for service under the Americans with Disabilities Act (ADA) **MUST BE UNABLE TO ACCESS THESE SERVICES** due to:

- Conditions which prevent them from getting to or from a GoApex fixed route bus stop, or transferring between vehicles **and/or**
- Conditions which prevent them from being able to plan for, board, ride, or disembark an ADA accessible fixed-route vehicle

The completed application must be submitted to GoWake Access within thirty (30) days of completion by the selected professional and can be returned to the applicant or sent to the following:

By Mail: GoWake Access  
Attn: GoApex ADA Eligibility Intake  
4401 Bland Rd  
Raleigh, NC 27609

By Email: [TransportationADAApplications@wake.gov](mailto:TransportationADAApplications@wake.gov)

**(PLEASE PRINT)**

Name of Applicant: \_\_\_\_\_

1. Capacity in which you know the applicant: \_\_\_\_\_

2. When was the applicant last treated or seen by you? \_\_\_\_\_

3. On average, how frequently is the applicant seen by you? \_\_\_\_\_

4. Has the applicant been diagnosed with a physical, cognitive, psychological, or other disability that would prevent them from using GoApex's fixed route bus service?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

5. Is the applicant's disability:

\_\_\_\_\_ Physical              \_\_\_\_\_ Cognitive              \_\_\_\_\_ Psychological              \_\_\_\_\_ Other

6. What is the applicant's disability (Please be specific but use layman's terms)?

7. What is the date of onset? \_\_\_\_\_

8. Does the applicant's disability or condition prevent the use of regular fixed route bus service?

\_\_\_\_\_ Yes, Sometimes              \_\_\_\_\_ Yes, Always              \_\_\_\_\_ No

If Sometimes or Always, please explain:

9. Could the applicant use regular fixed route buses with travel training? Travel training is an instructional process where individuals learn how to navigate and ride public transit safely and independently. It can be offered through one-on-one training or group training.

\_\_\_\_\_ Yes, Sometimes

\_\_\_\_\_ Yes, Always

\_\_\_\_\_ No

If Sometimes or Always, please explain:

11. How far can the applicant walk/travel by themselves or with the assistance of a mobility aid? (choose one of the options below and fill in a number beside it)

\_\_\_\_\_ Feet

\_\_\_\_\_ Blocks

\_\_\_\_\_ Miles

12. What is the expected duration of this individual's condition?

\_\_\_\_\_ Temporary: Approximate expected duration until \_\_\_\_\_

\_\_\_\_\_ Long-term: Potential for improvement or periods of remission

\_\_\_\_\_ Permanent: No expectation of functional improvement

I have read Parts A and B in their entirety

\_\_\_\_\_ Yes

\_\_\_\_\_ No

I agree with the information provided in Part B

\_\_\_\_\_ Yes

\_\_\_\_\_ No

If no, please explain:

Please choose the statement below which best represents your professional opinion regarding the applicant's use of public transportation:

\_\_\_\_\_ The applicant should be able to access fixed route public transportation successfully.

\_\_\_\_\_ The applicant can use fixed route public transportation successfully but may need to utilize Door to Door service **under certain conditions** due to a disabling condition or functional limitation.

Please explain conditions:

\_\_\_\_\_ The applicant cannot use fixed route public transportation due to a disabling condition or functional limitation and requires Door to Door service **without conditions**.

Printed Name \_\_\_\_\_

Title \_\_\_\_\_  
(If not a licensed physician, please indicate Title & Certification)

Organization/Practice \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

Email address: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Applicant Name \_\_\_\_\_

**FOR GOWAKE ACCESS USE ONLY**

APPROVED \_\_\_\_\_ DENIED \_\_\_\_\_

UNCONDITIONAL \_\_\_\_\_ CONDITIONAL \_\_\_\_\_ TEMPORARY \_\_\_\_\_

ISSUED BY \_\_\_\_\_ TITLE \_\_\_\_\_

DATE \_\_\_\_\_ FILE NUMBER \_\_\_\_\_