Hayward Operated Paratransit (The HOP)
A Measure BB funded Paratransit Program
Designed to Supplement and Complement the East Bay Paratransit Service System

APPLICATION INFORMATION

Thank you for inquiring about the Hayward Operated Paratransit (The HOP) program. **East Bay Paratransit** is the primary ADA mandated paratransit service for Hayward and Alameda County. *If under the age of 70, you must submit a completed Medical Statement Form, or be an existing East Bay Paratransit rider to be eligible for HOP*. If you have already applied with EBP, please submit a copy of your letter of eligibility or rider number.

Hayward Operated Paratransit Application: All riders must complete the 2 page HOP Paratransit application.

Applicants under 70 must either:

1) Provide your East Bay Paratransit rider number or letter of eligibility, OR
2) Submit a Medical Statement Form completed by a medical professional, Social Worker, Case Manager, or Community Health Worker.

If you are 70 years or older, the medical statement is not required.

Return completed forms to:

Mail: Hayward City Hall
Paratransit Program 777
B Street, 4th Floor
Hayward CA 94541
Email: paratransit@hayward-ca.gov
Fax: (510) 583-3650

If you have any questions regarding the enclosed information, please feel free to call or email our office at (510) 583-4230 or paratransit@hayward-ca.gov.

Hayward Operated Paratransit Program
Medical Statement Form

Only required for Riders under 70 years old

This form may need to be completed if the applicant does not meet the "Senior" age (70+) eligibility requirement of the Hayward Operated Paratransit service for which they are applying. For more information, please refer to the hayward-ca.gov/residents/paratransit or call the program directly.

Applicant's Name:____Birthdate: ____________________
Address: ____

Dear Physician, Social Worker, or Health Care Professional:

The above-named person is applying for the paratransit services in the city where they reside. In order to determine whether this applicant is eligible for paratransit services, applicant must provide verification that they are unable to utilize public transit services independently due to a disability/disabling health condition. All information provided below is confidential and is used for the sole purpose of establishing eligibility for paratransit services. Please help us determine the eligibility status of this individual by checking and/or completing all of the items below that apply to applicant. Please return this form to the applicant to submit with their paratransit application. Thank you.

I. Please describe the applicant's disability or disabling health condition that prevents use of public transit (i.e., buses and/or BART): Please attach additional pages if needed

____
____

II. Applicant's condition is: ☐ Permanent ☐ Temporary until (date): ____________________

III. Due to the conditions noted above, applicant is unable to use public transit services because they:

a. _ Cannot walk or travel in a wheelchair or scooter to or from a bus or train stop without the help of another person
b. _ Cannot board or get off a bus or train without the help of someone else
c. _ Cannot wait outside by him/herself for a bus or train to arrive
d. _ Cannot stand and maintain balance on a moving public transit vehicle
e. _ Cannot see, read and/or comprehend information signs, schedules, maps, etc.
f. _ Cannot hear and/or comprehend verbal information given by public transit personnel
g. _ Other reason(s): ____

IV. Are paratransit services needed for applicant to obtain life-sustaining treatment? ☐ Yes ☐ No
(i.e., dialysis, chemotherapy, radiation therapy, etc.)

PRACTITIONER'S STATEMENT: *I hereby state that the information provided above is correct.*

Practitioner's Name: ________________________________ ______________________________
(Print/Type) (Signature)

Date: ___________ Discipline: ☐ Physician ☐ Nurse ☐ Social Worker
☐ Other Practitioner (describe): ___________________
Agency/Organization Affiliation: ____
Address: ____

Telephone #: ___________________ Fax #: ______________________ Email: ______________________

Return to:	Hayward Operated Paratransit Program 777 B Street, 4th Floor, Hayward CA 94541 Tel: (510) 583-4230 | Fax: (510) 583-3650 Email: paratransit@hayward-ca.gov

NOTE: Please complete all questions in this application or your application may not be processed

Paratransit Application Form (rev. 10/4/24)

Name: ______________________ | ______________________ | ________
Last Name | First Name | Middle Initial

Cell Phone: (_____) ________ - ________ **Additional Phone:** (_____) ________ - ________

TTT/TTY Phone: (_____) ________ - ________ **Email:** ______________________

Home Address: ______________________ | ________ | ______________________ | ________
Street Address | Apt. # | City | Zip Code

Mailing Address: ______________________ | ________ | ______________ | ________ | ________
(If different from above) Street Address or PO Box | Apt. # | City | State | Zip Code

Name of Housing Facility (if applicable): ______________________

Birth Date: (MM/DD/YYYY) ________ / ________ / ________
Month Day Year

Gender ❑ Female ❑ Male ❑ Nonbinary ❑ Gender not listed here

What is your race/ethnicity? ***(Check all that apply)*** ☐ White ☐ African American/Black ☐ Pacific Islander/Native Hawaiian ☐ Asian ☐ Hispanic/Latino/Latine ☐ American Indian/Alaska Native Not Listed (please add) ______________________

1. **Have you been certified as eligible for rides with an ADA paratransit service? (i.e. East Bay Paratransit, Wheels Dial-A-Ride, Union City Paratransit)**
   ☐ Fully eligible ☐ Conditionally eligible **EBP Rider Identification #:**__________
   ☐ Not eligible/Denied ☐ Have not applied or **Interview Date:**__________________

2. **Do you use any of the following mobility aids or specialized equipment?** ☐ **No**
   ☐ Cane ☐ White Cane ☐ Walker
   ☐ Manual Wheelchair ☐ Power Wheelchair ☐ Power Scooter
   ☐ Service Animal ☐ Portable Oxygen Tank ☐ Other: ______________________

3. **Do you need a wheelchair lift to get in and out of a vehicle?**
   ☐ Yes ☐ No ☐ Don't know

4. **Do you typically travel with assistance from another person?** ☐ Yes ☐ No

5. **Please describe your disability or disabling health condition and explain how this condition prevents you from using public transit** (i.e. buses or BART)**:**
   ____
   ____

6. **Is the above condition you describe:** ☐ Permanent ☐ Temporary until:__________

7. **How often do you expect to use paratransit?** ☐ Daily ☐ 2-4x week ☐ 2-4x month

For Office Use Only: Client # __________

NOTE: Please complete all questions in this application or your application may not be processed

8. **How do you currently travel to your most frequent destinations? (Check all that apply)**
☐ ADA Paratransit (i.e. East Bay Paratransit)
☐ Drive myself ☐ Someone drives me ☐ Bus/BART ☐Taxi ☐Uber/Lyft
☐ Other: ___________________________

9. **Are you on any of the following forms of income/benefit assistance?** ***(check all that apply)***
☐ **Supplemental Security Income (SSI)** ☐ **Medi-Cal** ☐ **CalWorks**
☐ **General Assistance (GA)** ☐ **Cash Assistance Program for Immigrants (CAPI)**

10. **Gross *Individual* Monthly Income:** _______________

11. **Gross *Household* Monthly Income:________________# of people in household**: _____

12. **Would you like help learning to use paratransit?** ☐ **YES** ☐ **NO**

13. **Would you like help with appointments or running errands?** ☐ **YES** ☐ **NO**

14. **What is your living arrangement?** ☐ Live alone ☐ Live w/ spouse/partner
☐ Live with adult children ☐ Live in a skilled nursing facility/nursing home
☐ Live in assisted living/residential care home ☐ Other: ___________________________

15. **What language(s) do you speak?** Preferred Language: _______________________
Other Language(s): ____

Emergency Contact Person: ____
Relationship to you:___________________Daytime phone: (______)___________________
Cell phone: (____)____________________Email: _________________________________

Do you manage your own affairs and deal with your own mail? ☐ Yes ☐ No
If "No," to whom should correspondence be mailed?
Name:_____________________________________Relationship: ________________
Phone: (_____)_____________________Email __________________________________

16. **If you need future information provided to you in an accessible format, please check which format you prefer:** ☐ Large Print ☐ Audio file ☐ Braille ☐Electronic File

17. **Do you (or your care giver) wish to receive your introduction packet and future changes by e-mail?** (Please note vouchers will still be mailed to you)**:**
☐ Yes ☐ No ***If "Yes", please provide your (or your care giver's) e-mail address so we can send you the information**____

18. **How did you hear about HOP?** ____

I certify that the information in this application is true and correct. I understand that knowingly falsifying the information will result in denial of service. I give the City permission to verify whether I am enrolled with East Bay Paratransit. I understand that all application information will be kept confidential, and only the information required to provide the service I request will be disclosed to those who perform the services.

*Applicant's Signature:________________________________ *Date: ____________________

Name of Person who assisted you with application/Phone #: ___________________________________

For Office Use Only: Client # __________

Hayward Operated Paratransit (HOP) Means-Based Fare (MBF) Subsidy

The HOP (Hayward Operated Paratransit) Program offers reduced cost paratransit services to eligible HOP participants. To qualify for an additional subsidy, referred to as our Means-Based Fare Subsidy (MBF), applicants must enroll in HOP and meet the U.S. Department of Housing and Urban Development (HUD) extremely low-income guidelines (see below). Income information is required of all members of the household over 18 years of age.

To Apply

To be considered for the additional MBF subsidy, please submit the following **income documentation**:

1. Copy of social security benefit statement, disability benefit statement, and/or pension-investment benefit statement;
2. Bank statements for previous two months;

Please mail, email or fax your documentation to HOP. *Once all the required documentation is received, staff will review your request. You will be notified of the status of your application within 5-10 business days.*

Eligibility - FY 2024 HUD Extremely Low-Income Limits (maximum income/household size):

# Persons in Household:	1	2	3	4	5	6	7	8
Extremely Low-Income Limits	$32,700	$37,400	$42,050	$46,700	$50,450	$54,200	$57,950	$61,650

About the Means-Based Fare Subsidy

HOP offers means-based fares to eligible clients for reduced or no cost paratransit services. The means-based fare only covers the first $20 of a trip. Any costs over the $20 threshold are the rider's responsibility. To qualify, applicants must:

- Enroll in HOP and be in good standing, and
- Meet HUD extremely low-income guidelines (see above). Income information is required of all members of the household over 18 years of age.

HOP will cover a maximum of $20.00 of rides scheduled through 2-1-1. With the exception of medical related trips, costs over $20.00 per ride are not covered by HOP. All costs over $20.00 are the responsibility of the rider. HOP will cover up to a maximum of $35.00 for medical-related rides (requires verification from 2-1-1).

If you have any questions or concerns, please contact our office at 510-583-4230 or paratransit@hayward-ca.gov.