VAMONOS
ELIGIBILITY APPLICATION

The information obtained in this certification process will be used by the City of Las Cruces *ROAD**RUNNER** Transit* for the provision of VAMONOS transportation services. The information will only be shared with other transit providers to facilitate travel in those areas but will not be provided to any other person or agency.

1. Name:_____
2. Address:_____

   _____ State:_____ Zip:_____
3. Telephone Number: (Home)_____ (Work)_____
4. Date of Birth:_____/_____/_____

5. What is the disability, which prevents you from using our fixed-route service?_____

   _____

   _____

   Is this condition temporary? ☐Yes ☐No

   If yes, expected duration, until: / /

6. How does this disability prevent you from using fixed-route services? Please explain in detail. (Use an additional sheet if needed.) _____

   _____

   _____

   _____

   _____
7. Are there any other effects of your disability of which we need to be aware? _____

   _____

   _____

The following information will be used to ensure that an appropriate vehicle is utilized to provide your transportation and that an accurate analysis of your trip requests can be made by VAMONOS.

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

___Wheelchair ( )Manual ( )Electric ___Powered Scooter ___Cane

___Personal Care Attendant ___Crutches ___Guide Dog ___Other:_____

9. Do you require a Personal Care Attendant when you travel using transit?

___Yes ___No

10. Please answer the following questions:

a. Can you travel 200 feet without the assistance of another person?

Yes___ No___ Sometimes_____

b. Can you travel ¼ mile without the assistance of another person?

Yes___ No___ Sometimes_____

c. Can you climb three 12-inch steps without assistance?

Yes___ No___ Sometimes_____

d. Can you wait outside without support for 10 minutes?

Yes___ No___ Sometimes_____

11. I hereby certify that the information given above is correct.

Signed:_____ Date:____/_____/_____

12. If this application has been completed by someone other than the person requesting certification, that individual must complete the following:

Name:_____

Address:_____

City:_____State:_____Zip:_____

Daytime Phone:_____

Signed:_____ Date:_____/_____/____

AUTHORIZATION FORM

In order to allow the VAMONOS Coordinator to evaluate your request, it may be necessary to contact a physician or other professional to confirm the information you have provided. Please complete the following information.

The following Physician__ Health Care Professional__ Rehabilitation or Social Service Agency Professional____(check one) is familiar with my disability and is authorized to provide information to VAMONOS to complete this certification.

Name:_____

Address:_____

City:_____State:_____Zip:_____

Telephone Number:_____

Print Name:_____

Signature:_____ Date:_____/____/____

This application form can be made available in alternative formats upon request to (575) 541-2777/Voice

MAIL COMPLETED APPLICATION TO:

ROADRUNNER TRANSIT
VAMONOS COORDINATOR
P. O. BOX 20000
LAS CRUCES, NM 88004

☎ DIRECT QUESTIONS TO:
(575) 541-2777

REQUEST FOR PROFESSIONAL VERIFICATION

The attached Authorization Form has been submitted by _____, who has indicated that you can provide information regarding his/her disability and its impact upon his/her ability to use VAMONOS transit services. Federal law requires that the City of Las Cruces Roadrunner Transit provide paratransit services to persons with disabilities unable to use regular fixed-route transit services. The information you provide will allow us to make an appropriate evaluation of this request and its application to specific trip requests. Thank you for your cooperation.

Capacity in which you know the applicant:_____

_____

Medical diagnosis of condition causing disability:_____

_____

Is the condition temporary? ☐No ☐Yes

If Yes, expected duration, until _____/_____/_____

If the person has a disability effecting mobility:

Is the person:

Able to walk 200 feet without assistance?

Yes___ No___ Sometimes_____

Able to walk ¼ mile without assistance?

Yes___ No___ Sometimes_____

Able to climb three 12-inch steps without assistance?

Yes___ No___ Sometimes_____

Able to wait outside without support for 10 minutes?

Yes___ No___ Sometimes_____

Does this person use any mobility aids? If so, what? _____

If the person has a visual impairment:

Visual acuity with best correction: ____Right Eye ____Left Eye ____Both Eyes

Visual fields: ____Right Eye ____Left Eye ____Both Eyes

If the person has a cognitive disability:

Is the person able to:

Give addresses and telephone numbers upon request? ___Yes ___No

Recognize a destination or landmark? ___Yes ___No

Deal with unexpected situations or unexpected change in routine? ___Yes ___No

Ask for, understand, and follow directions? ___Yes ___No

Safely and effectively travel through crowded and/or complex facilities? ___Yes ___No

Is there any other effect of the disability of which the City of Las Cruces RoadRunner Transit should be aware? Please describe:_____

_____

_____

_____

_____

Your Name & Title:_____

Office Address:_____

Office Phone Number:_____

Signature:_____ Date:_____/____/____