ACCESS AT

ADA PARATRANSIT ELIGIBILITY APPLICATION AND INSTRUCTIONS

Dear Applicant:

Thank you for inquiring about applying for **Advance Transit's** ***ACCESS AT*** paratransit eligibility. Enclosed is a copy of an application for Certification of ADA Paratransit Eligibility, as well as an instruction sheet outlining the certification process and an informational brochure about Public Transit and ADA Paratransit services.

Please read these enclosed materials carefully before completing the application.

ACCESS AT is the paratransit service **Advance Transit** (**AT**) provides to individuals who are unable to use fixed-route bus service because of a disability. An inability to use fixed-route bus service may include being unable to travel to and from bus stops, board or exit buses, or understand how to ride and use the bus system.

ACCESS AT provides shared-ride, curb-to-curb service to persons determined to be "ADA paratransit eligible" for those trips that cannot be made using the fixed-route service. You may, for example, be able to use bus service for some trips if stops are nearby and there are no barriers that prevent you from getting to and from the bus. At other times, you might not be able to travel to and use the buses. ***ACCESS AT*** is meant to assist you at these times.

There are four types of eligibility:

Conditional Temporary: You are able to use the fixed-route bus sometimes and need paratransit sometimes. The functional limitation is expected to improve.

Conditional Permanent: You are able to use the fixed-route bus sometimes and need paratransit sometimes. The functional limitation will not improve and may become worse.

Unconditional Temporary: You cannot use the fixed-route bus due to a functional limitation. The functional limitation is expected to improve.

Unconditional Permanent: You cannot use the fixed-route bus due to a functional limitation. The functional limitation will not improve and may become worse.

To enable us to accurately determine your eligibility for this service, **please complete the enclosed application as thoroughly and accurately as possible.** The questions are meant to determine the circumstances under which you can use fixed-route or paratransit services.

If you need assistance completing the form, or have questions, please contact the ***ACCESS AT*** office. You may call us anytime during normal office hours. Our office is open Monday through Friday from 8:00 AM until 4:30 PM. The phone number is 1-802-295-1824 (voice) or TTY 711. This letter and application is also available in large print, and other alternative forms. This information is also available for download on our website at www.advancetransit.com.

After you have completed the applicant information, please have a licensed health care professional who is familiar with your health condition or disability and your functional abilities and limitations complete the health care professional information. You and your health care professional must sign the application. ***If any sections are left blank the application will be returned to you as incomplete.*** The information you provide in this application is confidential.

Please *do not* attach medical documentation or information to this application, other than your health care professionals signed statement. You may bring the medical information with you when you have your interview.

Please mail your completed application and the health professional statement to us at:

ACCESS AT
Advance Transit, Inc.
PO Box 1027
Wilder, Vermont 05088

Within a few days of receiving your completed application packet, you will be contacted by telephone to schedule an in-person interview and functional assessment to determine your abilities to use **AT**'s fixed-route service.

Completed applications will be processed within 21 days of receipt. You will then be notified in writing of your eligibility status. If additional time is required to complete the evaluation and determination, you will be given temporary eligibility.

If we determine that you are able to use **AT**'s fixed-route service, and are therefore ineligible for ***ACCESS AT*** , we will notify you of the reason(s) for this determination. You may appeal this decision in writing. However, ***ACCESS AT*** service will not be provided during the appeal process, unless the appeal process cannot be concluded within 30 days.

Applicant Information

Title: Mr. Mrs. Miss Ms. Social Security Number _____

Name_____

Mailing address_____

_____

Physical address (if different from mailing)_____

_____

Telephone/TDD Number (day)_____ (evening)_____

Date of Birth_____/_____/_____ Gender: [ ] Male [ ] Female

Primary Language: [ ] English [ ] Spanish [ ] Sign [ ] Other:_____

Accessible Formats: [ ] Standard Print [ ] Large Print [ ] Braille [ ] Audio CD

[ ] Other:_____

Type of Eligibility: [ ] Conditional Temporary [ ] Conditional Permanent

[ ] Unconditional Temporary [ ] Unconditional Permanent

Please give us the name and phone number of a friend or relative we can call in case we are unable to reach you at your regular number:

Name:_____ Relationship:_____

Telephone/TDD (day)_____ (evening)_____

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

Name:_____

Address:_____

_____

Telephone: (day)_____ (evening)_____

Signed:_____ Date:_____

In case of emergency: please list names of two people, including support professionals, agencies or others familiar with your disability that ***ACCESS AT*** can contact:

Name:_____ Work#_____ Home#_____

Address:_____

Relationship:_____

Name:_____ Work#_____ Home#_____

Address:_____

Relationship:_____

About Your Disability

1. Do you have a disability, which prevents you from using the Advance Transit fixed-route bus service? [ ] Yes [ ] No

If yes, please describe <u>any and all physical, mental, visual, or functional disabilities which prevent</u> you from using Advance Transit fixed-route bus services.

_____

_____

_____

2. Explain how your disability prevents you from independently using fixed-route bus service:

_____

_____

_____

_____

_____

3. Are the conditions you described? [ ] Permanent [ ] Temporary [ ] Vary day to day

If temporary, how long do you expect to have this disability?_____(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:_____

6. Do other weather/lighting conditions (wind, dusk/dark and or glare) affect your disability? 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. Does the extent of your disability change after medical treatment?

[ ] Yes [ ] No [ ] Sometimes

If yes or sometimes, please explain:_____

_____

_____

10. Are there any other comments or additional information relating to your disability that you would like to explain?

_____

Traveling To and From Bus Stops

1. Are you able to locate fixed-route bus stops, destinations, locations, or cross streets independently? [ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:_____

_____

2. Are you able to travel independently after dark? [ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:_____

_____

3. Are you able to safely and independently travel 200 feet without help from another person?

[ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:_____

_____

4. Are you able to safely and independently travel ¼ mile (about 4 blocks) without help from another person? [ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:_____

_____

5. Are you able to reach and return from your neighborhood bus stop independently?

[ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:_____

_____

6. Are you able to wait outside without assistance or support for ten (10) minutes?

[ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:_____

_____

7. Are you able to leave and return to your regular destinations (local bus stops) independently?

[ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:_____

8. Are you able to wait longer than 15 minutes? [ ] Yes [ ] No [ ] Sometimes

If so, how long can you wait? _____minutes

9. Are you able to travel on flat surfaces in good weather? [ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:_____

_____

10. Are you able to travel on slight inclines in good weather? [ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:_____

_____

11. Are you able to get to and from the nearest public transit stop?

[ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:_____

_____

12. Could you wait if there were a seat or a bus shelter? [ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:_____

_____

13. Could you wait if there were **no** seat or bus shelter? [ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:_____

_____

14. How long are you able to wait for a bus to arrive? _____minutes

Boarding and Alighting the Bus

1. Can you safely and independently walk up and down three (3) 12 inch steps?

[ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:_____

_____

2. Are you able to board, ride, or exit a wheelchair accessible bus without assistance?

[ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:_____

_____

3. Are you able to grasp handles or railings while boarding or exiting a bus?

[ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:_____

_____

4. Are you able to board or exit a vehicle if it has a lift or kneeler that lowers the front of the bus? [ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:_____

_____

5. Are you able to get on and off a bus without assistance? [ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:_____

_____

6. Have you ever had training to learn how to travel around the community or on how to use the fixed-route buses? [ ] Yes [ ] No

7. Would you like information about free training to use the fixed-route buses? [ ] Yes [ ] No

8. List the three places you go most often and how you get there now:

A. Where do you go?_____

Address?_____

How often do you go there?_____

How do you get there now?_____

B. Where do you go?_____

Address?_____

How often do you go there?_____

How do you get there now?_____

C. Where do you go?_____

Address?_____

How often do you go there?_____

How do you get there now?_____

Service Delivery

1. Do you use a wheelchair or scooter? [ ] Yes [ ] No

How heavy is it when occupied? _____pounds

A wheelchair is defined as a mobility aid that belongs to any class of three-or-more-wheeled devices, usable indoors, designed or modified for and used by individuals with mobility impairments, whether operated manually or powered.

Advance Transit must carry a wheelchair and its user, as long as the lift can accommodate the size and weight of the wheelchair and its user. The wheelchair and users weight must be within the capacity of our bus lift to meet our safety requirements.

2. Do you use any of the following mobility aids or specialized equipment when traveling? Check all that apply.

[ ] Manual Wheelchair [ ] Long White Cane [ ] Cane

[ ] Crutches [ ] Communication Board [ ] Service Animal

[ ] Power Wheelchair [ ] Power Scooter (3 wheeled)

[ ] Walker [ ] Large Power Chair (exceeds ADA)

[ ] Other Aid:_____

3. If you use a wheelchair or scooter, will you use it on paratransit?

[ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:_____

_____

4. Are you able to wait 15 minutes at a public bus stop with your mobility device?

[ ] Yes [ ] No [ ] Sometimes

If no or sometimes, please explain:_____

_____

5. Do you require an attendent (personal care, sighted guide) to travel with you? An attendent may assist you with any personal or travel needs, such as crossing the street, navigating stairs, etc.

[ ] Yes [ ] No [ ] Sometimes

If yes or sometimes, please explain:_____

_____

6. Do you travel with children under the age of 10? [ ] Yes [ ] No

Release of Information

I, the applicant, understand that the purpose of this application is to determine my eligibility to use ***ACCESS AT*** service. I hereby authorize my health care professional to release information about my disability and its affect on my ability to travel, which may be needed in connection with my request for ADA paratransit eligibility certification. It is my understanding that the information released will be used solely to determine my ADA paratransit eligibility. I agree to release this information to Advance Transit Inc. and its functional assessment contractor, Dartmouth Hitchcock Medical Center Rehabilitative Medicine Clinic. This release authorizes the contractor to directly contact my health care professional for further information or clarification of the information provided.

I agree to notify Advance Transit, Inc. of any changes in the status of my disability that affects my ability to use complementary paratransit service. I understand that providing false information in this application could result in a loss of ADA paratransit service as well as a penalty under the law.

I hereby certify that I am the individual requesting certification for ADA complementary paratransit service and that all information contained in this application is true and accurate:

Signed:_____ **Date:**_____

Printed Name of Applicant:_____

If the applicant is a minor or has a legal guardian the parent or guardian must sign this application, and attest to the accuracy of the information contained herein.

Signature of Parent or Legal Guardian:

_____ **Date:**_____

FOR INTERNAL USE ONLY:

Application reviewed for completeness by:_____

Date completed application received:_____

Application tracking number:_____

ACCESS AT
Attachment to Application for Complementary Paratransit Service

Dear Health Care Professional:
Federal law requires that Advance Transit (AT) provide complementary paratransit service to persons who cannot use the accessible fixed route bus system.

The information you provide in the attached Professional Verification will allow AT to make an appropriate evaluation of the applicant's mobility and determine how we may best meet their needs.

In accordance with the "*Americans with Disabilities Act of 1990*" (ADA) and its regulations, Section 37.123(e), there are two specific circumstances under which a person would be considered ADA eligible for AT's ***ACCESS AT*** service:

1. Any individual with a disability who is unable, as a result of a physical or mental impairment (including a vision impairment), and without the assistance of another individual (except the operator of a wheelchair lift or other boarding assistance device), to board, ride, or disembark from any vehicle on the system which is readily accessible to and usable by individuals with disabilities.
2. Any individual with a disability who has a specific impairment-related condition which prevents such individual from traveling to a boarding location or from a disembarking location on such system.

Please note this does not include persons who find it uncomfortable or difficult to get to and from bus stops.

Resources for this service are limited, and your evaluation of each person must be based solely upon the individual's ability to use regular transit service. All fixed route buses are ADA accessible. Your verification should consider only the presence of a disabling condition, not the applicant's age or economic status. Please exercise care in evaluating applicants for this service. False verification could result in overloading the ***ACCESS AT*** system and adversely impact persons legitimately qualified to use this service.

If you have any questions about the application or the review process, please contact Advance Transit at (802) 295-1824**.**

Sincerely,

Van J. Chesnut
Executive Director

This part of the application form should be completed by one of the following health care professionals **who is currently treating the applicant for their disability, and** is authorized to provide this information to Advance Transit in order to complete the application for certification:

Check the appropriate box to identify your profession

- ☐ a rehabilitation specialist
- ☐ an orientation and mobility specialist
- ☐ an occupational or physical therapist
- ☐ an independent living counselor
- ☐ a social worker
- ☐ a vocational rehabilitation counselor
- ☐ an ophthamologist or optometrist
- ☐ a physician or registered nurse
- ☐ a psychologist or psychiatrist
- ☐ a mental health counselor

Applicant name:_____

1. In what capacity do you know the applicant and for how long?

_____

2. Is the applicant your regular client? [ ] Yes [ ] No

3. Please indicate all the medical diagnoses of the applicant's disability. (Please print clearly.)

_____

_____

4. Is the condition temporary? [ ] Yes [ ] No
   If yes, please specify the time frame (example:6 months) within which you anticipate the applicant to recover or next reevaluation. _____

5. Is this condition likely to worsen? [ ] Yes [ ] No

6. Does the applicant require use of the following? (check each, where it applies)

	Yes	No	Sometimes
Manual wheelchair	____	____	____
Motorized wheelchair	____	____	____
Cane, crutches, or walker	____	____	____
Service animal	____	____	____
Personal care attendant	____	____	____

7. Is the applicant able to do any of the following with the use of a mobility aid and without the assistance of another person?

	Yes	No	Sometimes
Travel ½ block?	____	____	____
Travel 1 block?	____	____	____
Travel 2 blocks?	____	____	____
Travel 4 blocks or more?	____	____	____
Climb three 12" steps?	____	____	____
Wait outside without support for 10 minutes?	____	____	____

If "No" or "Sometimes", describe in detail any factors which would have an adverse impact on the applicant's abilities to travel or wait outside.

_____

_____

8. Can the applicant independently cross the street? [ ] Yes [ ] No

9. Under what circumstances do you believe the applicant could independently use accessible AT fixed route bus service? Please describe. (example: if person receives transit orientation, if distance to bus stop is not too great)

_____

_____

10. Is the applicant able to:	Yes	No
Give addresses and phone numbers upon request?	____	____
Recognize a destination or landmark?	____	____

10. Is the applicant able to: (Continued)	Yes	No
Sign his/her name?	____	____
Deal with unexpected situations?	____	____
Ask for, understand, and follow directions?	____	____

11. Is the applicant currently taking any medication that would likely have an impact in their travel abilities or limitations? [ ] Yes [ ] No
If yes, please list if there are any side effects?_____

_____

12. Does the applicant experience episodic days? [ ] Yes [ ] No

13. Is the disability the same every day? [ ] Yes [ ] No

14. Does weather impact the applicant's ability to travel? [ ] Yes [ ] No
If yes, please explain and list the temperatures at which the applicant would be impacted.

_____

_____

I hereby affirm that the statements made herein are true and correct.

Signature:_____ Date:_____
Professional's signature

Name:_____
Professional's name printed

Office Address:_____

City:_____ State:_____ Zip code:_____

Office phone:_____
Please return this completed form directly to your patient.