Kingston Citibus

Americans with Disabilities Act (ADA)
Paratransit Eligibility

Paratransit Application

Questions about this form?
Call Kingston Citibus at (845)331-3725 voice, TDD (845)331-5350
Mail applications to: **Kingston Citibus**
17 Hoffman Street, Kingston, NY 12401

Complete all parts of the application form. Applications that are not full completed will be returned, which will delay your eligibility determination.

This application and future written information are available in large print. Does large print better suit your needs? □ Yes □ No

PART A Applicant Data

please print or type

Name: _____

Street Address: _____Apt. # _____

City: _____Zip Code: _____

Day Telephone: ( )_____Evening Telephone: ( )_____

Birth Date: ___/___/_____ Cell Phone: ( )_____

MAILING ADDRESS *(if different from above)*

Street Address: _____Apt. #_____

City:_____ Zip code:_____

Email Address: _____

EMERGENCY CONTACT PERSON

Name: _____

Day Telephone: ( )_____ Evening Telephone: ( )_____

Cell Phone: ( )_____

1.Which of the following mobility/communication aids do you use? (Please check all that apply.)

□

□ Cane □ Manual Wheelchair □ Service Animal □ Transfer Board

□ Crutches □ Electric Wheelchair □ Personal Care Attendant □ Other _____

2. If you use a wheelchair or scooter:

Must not exceed the weight specifications of the vehicle.

3. Does your health condition/disability require you to use paratransit service:

□ Seasonally (Nov. – Apr.)

□ Until I meet travel training

□ Permanently □ Temporarily
If temporarily, for how long? _____Week(s) _____Month(s)

4. When using paratransit service, does your health condition/disability require you to travel with a personal care attendant (PCA)*? □ Yes □ No

* A PCA is a person traveling as an aide who is designated or employed by a person with disabilities to help that person meet his or her personal needs and/or facilitate travel.

PART B Questions about using regular-route public transit

Complete Part B even if you are unable to use regular-route transit. This information will assist us in determining how your disability/health condition affects your ability to use regular-route bus service.

5. Do you now independently use regular-route buses? □ Yes □ No □ Sometimes
If "Yes" or "sometimes," how often? _____Week(s) _____Month(s) _____Year(s)

Which of the following best describes how you use regular-route buses?

□ To travel to and from one destination only
□ To travel to and from a few destinations
□ To travel to and from many different destinations

Explain what prevents you from independently using public transit services.

_____

_____

_____

6. Using a mobility aid or on your own, how far are you able to travel without the assistance of another person? □ 3 blocks □ 6 blocks
□ 9 blocks □ < 3 blocks

7. I can wait for a regular-route bus (check all that apply):
   - □ Only if there is a bench or shelter
   - □ No more than 15 minutes □ More than 15 minutes

8. Please check all categories below as they relate to your ability to use regular-route buses:

I am:	Yes	No	Sometimes
A. Able to tolerate very hot or very cold weather	□	□	□
B. Able to recognize destinations, bus stops, or landmarks	□	□	□
C. Able to tolerate air pollution (smog, fumes, perfume)	□	□	□
D. Free from night blindness	□	□	□
E. Able to hear and process spoken words or auditory	□	□	□
F. Able to recognize printed information	□	□	□
G. Able to communicate needs	□	□	□
H. Able to follow directions	□	□	□
I. Able to recognize curbs and other drop-offs	□	□	□
J. Able to travel independently along sidewalks and pedestrian ways	□	□	□
K. Able to cross streets independently	□	□	□
L. Able to find the correct bus stop	□	□	□
M. Able to identify correct bus	□	□	□
N. Able to safely enter/exit the bus(this includes stepping up three steps with maximum height of 16 inches)	□	□	□
O. Able to get on and of a bus that has a lift platform(either standing or with mobility aid)	□	□	□
P. Able to deposit fare into the fare box or show bus pass	□	□	□
Q. Able to get to a seat/wheelchair position and remain seated during a bus trip	□	□	□
R. Familiar with what to do if I miss my bus	□	□	□

If you checked "No" or "Sometimes" to any of the items in question 8, please explain:

PART C Applicant signature

The information provided on this form is private data and is used to determine ADA paratransit eligibility. The ability to determine your eligibility is based on receiving all of the information requested on this form. All medical or location information pertaining to application for or users of ADA paratransit service is private, except the name of the applicant or user. Any other information cannot be released to anyone else, unless the applicant or user authorizes the release in writing. If you are determined ADA paratransit eligible, information about your eligibility status will be kept on file at the City of Kingston Citibus Office.

I certify that all information on this application form is accurate. I understand that misinformation or misrepresentation of facts will be cause for disqualification or rejection of my ADA eligibility. I also understand that additional information relating to my health condition or disability may be required to determine eligibility. This information may be obtained through an in-person assessment or by requesting information from a professional who understands my health condition or disability. Additional information will be required only when the information provided on the application form does not clearly determine ADA paratransit eligibility.

Applicant's Signature: _____*Date:* _____

*If the applicant is not his/her own guardian , the following information about the guardian is required:

Guardian's Name:_____

Day Phone: ( ) _____Cell Phone: ( ) _____

Guardian's Signature: _____*Date:*_____

*If someone other than the applicant's guardian is preparing this form, please provide the following information about the preparer.

Name: _____

Day Phone: ( )_____Cell Phone: ( )_____

Preparer's Signature: _____*Date:*_____

Kingston Citibus Application

PROFESSIONAL VERIFICATION

SECTION A

This portion of your Americans with Disabilities Act (AD) paratransit application requires information from a professional you identify as being familiar with your disability/health condition.

Here's what you need to do:

1. **Complete and sign** the authorization form (Section B).
   Keep Section A for your future reference.

2. **Send** the completed authorization form (Section B) and the Professional Verification form (Section c) to the professional you have identified.

3. The professional will send Section B and Section C back to you.

4. You need to ***return the following items in the enclosed envelope.***
   - **The ADA Paratransit Application**
   - **Section B of this form**
   - **Section C of this form**

Mail to: *Kingston Citibus*
17 Hoffman Street, Kingston, NY 12401

Incomplete applications will be returned to you.

Anyone needing assistance in filling out this application may call the Citibus Office at **845-331-3725.** You may call between the hours of 8:30 and 4:30 pm for an appointment or assistance. *All information is kept confidential.*

SECTION A KEEP THIS SHEET FOR YOUR REFERENCE

How long does the application process take?

Once all required information is received, you will be notified within 14 days regarding your eligibility status. If you are not satisfied with the decision you have the right to appeal in writing to the Kingston Citibus Office at 17 Hoffman Street, Kingston, NY 12401. Once an appeal is received in writing you may be heard in person by contacting The Kingston Citibus Office at 845-331-3725.

Who qualifies as a professional?

It is important that you select a professional who is familiar with your disability/health condition and your functional abilities and limitations. Make sure that your professional meets the criteria necessary in helping to determine your eligibility. Information will be accepted from the following professionals:

- physician or registered nurse
- licensed independent clinical social worker/licensed independent social worker
- psychologist/psychiatrist
- occupational or physical therapist
- certified rehabilitation counselor
- certified recreational therapist
- speech language pathologist

Why is an Authorization Release form necessary?

An applicant's authorization is required before the professional can release information to Citibus Paratransit. The information is deemed private and is only used in assisting us in determining an applicant's ADA Paratransit eligibility.

What are the rules for the Paratransit service?

- The Paratransit bus will pick up at curb side.
- If assistance is needed a personal care attended is recommended or assistance from the driver can be requested at the time of the appointment.
- Appointments should be cancelled the day prior to service.
- Service will be refused if a passenger becomes violent, seriously disruptive, or engages in illegal conduct (37.5(h)).
- One companion is permitted to accompany the ADA rider.

What are the hours and cost of using Paratransit Service?

- Hours of Operation:
  Monday - Friday > 6:30 am until 7:30 pm; Saturday > 9:30 am until 5:30 pm
- No Service on New Years Day, Memorial Day, July 4th, Thanksgiving Day and Christmas Day.
- Fare: $2 one way within the city limits; $4.00 one way outside city limits
  1. Non ADA rider > same fare as ADA rider
  2. Personal Care Attendant > no charge

3.

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Authorization Instructions

1. **Complete and sign** the ***"Authorization to release Information "*** *(Section B***).**
   Keep *(Section A)* for future reference.

2. **Send** the completed ***Authorization Form (Section B)*** and the ***Professional Verification Form (Section C)*** to your designated professional.

3. **Wait** for the professional to return ***Sections B and C*** to you. Check with your Professional if you don't receive your information.

4. **Put your application/recertification form** and **Sections B & C in the same envelope and mail to** :
   Kingston Citibus, 17 Hoffman Street, Kingston, NY 12401

SECTION B Authorization to Release Information

(when complete send to the professional you named)

Applicant's Name: _____
Date of Birth: ___/___/_____
Applicant's Address: _____Apt. #_____
City:_____ Zip code:_____
Applicant's Telephone: ( )_____ Cell Phone: ( )_____

I authorize the following professional to release to Kingston Citibus specific information as requested. It is my understanding that the information released will be used solely to determine my ADA paratransit eligibility. I understand that I may revoke this authorization at any time. Unless revoked, this form will allow that professional listed below to release information described for six months after the date appearing below.

Name of Professional: _____Title:_____

Applicant's Signature: _____*Date:*_____

Guardian's signature required if the applicant is not his/her own guardian,

*Guardian's Signature:*_____*Date:*_____

SECTION C Kingston Citibus Professional Verification Form

Dear Health Care Professional:

You are being asked to provide information regarding this individual's disability. The Federal Law is very specific about ADA paratransit eligibility. The law restricts eligibility to individuals who,

1. as a result of their disability, cannot board, ride, or disembark from a regular fixed route bus or
2. have a specific impairment-related condition which prevents them from getting to or from a bus stop.

PLEASE NOTE: This ***does not*** include persons who find it difficult or uncomfortable to get to and from bus stops. In providing information you should consider only the presence of a disability or health condition and not the applicant's age or economic status.

This section must be filled out for all applicants

GENERAL INFORMATION

- Describe diagnosed disability you are currently treating this individual for:_____

- Date of onset _____/_____/_____
- Date of last visit _____/_____/_____
- How long have your worked with the individual? Since _____/_____/_____
- Is disability temporary ___ or permanent ____?
  If permanent is disability progressive? Yes ____ No ____
  If temporary please give best estimate of rate of recovery. <6 mos. ___>6mos.___>1 yr _
- Is therapy part of treatment? Yes ____ No ____ If yes, give brief description_____

- Do Temperature extremes affect the individual?
  (Ex. Heat index of >85 degrees or wind chill <10 degrees) Yes ___ No___ If yes, how so?_____
- Please list all medications. _____

- Is this individual compliant with taking medication? Yes _____ No_____
- Does the individual currently use regular route public transportation?Yes__ No__ Not Sure__
- Can the individual walk? Yes___ No___
- Does the individual use a mobility aid? Yes ___ No___ Please List _____

This section must be filled out for all applicants

GENERAL INFORMATION *Cont'd*

- How long has individual been using the device(s)?

- How far can the individual walk? (with mobility aid if applicable)
  3 blocks___ 6 blocks___ 9 blocks___ <3 blocks
- With treatment/therapy will this distance increase? Yes___ No___
- Please indicate the expected distance after treatment/therapy:
  3 blocks___ 6 blocks___ 9 blocks___ <3 blocks
- Give best estimate of length of time required to achieve improvement.

Please complete only those sections that apply to this individual

NEUROLOGICAL IMPAIRMENT/HEAD INJURY

- Does the individual experience seizure? Yes___ No___ Date of last seizure ___/___/___

  Please give no. of seizures ____ and frequency _____
- Is the individual's judgment impaired? Yes___ No___
- Is behavioral inhibition impaired? Yes___ No___
- Does judgment and inhibition impairment prevent the individual from independently traveling outside the home or immediate environment? Yes___ No___
- When traveling independently does the individual have the ability to:
  (check all that apply)
  Get help if lost ___ recognize & avoid danger___ Cross streets safely___
  Follow written directions___ Communicate needs___ Process information___
  Understand and follow schedule to get to places on time___

VISUAL IMPAIRMENT **Fill in if applicable*

- Does the individual require any accommodations, adaptations, low vision aids, ect? Please list:_____

- How does the individual's visual impairment affect their ability to move about in the environment?

  _____

EMOTIONAL/BEHAVIOR ISSUES

- Does the individual experience any of the following:
  auditory hallucinations__ visual hallucinations__ delusions___
- Does this prevent the individual from being oriented to person, place and time? Yes___ No___
- Is the individual currently being treated for any of the following:
  anxiety___ depression___ panic attacks___ schizophrenia___ other_____
- For anxiety panic attacks please indicate on average the frequency and length of attacks.
  Per day ___ per week___ per month___ per year___ approx. duration: _____

COGNITIVE/MENTAL IMPAIRMENTS

- Please describe the functional limitations caused by this impairment?

  _____

  _____

- Is the individual's judgment impaired? Yes___ No___
- If yes, please describe to what extent or give an example._____

- Is individual able to live independently? Yes___ No___

  Additional Comments:

  _____

  _____

Kingston Citibus will make the final determination of the applicant's eligibility

Doctor/Health Care Professional Signature: _____

Date: _____

PLEASE RETURN FORM TO APPLICANT – PLEASE PRINT so that we may contact you if needed

Name of Professional _____**Date:** _____/_____/_____

Title: _____

Street Address: _____

City: _____

Telephone Number:_____**Fax:**_____