



# 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:

- Is it more than 30 inches wide?     Yes     No
- Is it more than 48 inches long?     Yes     No
- Is the combined weight of the device and occupant more than 600 pounds?  
 Yes     No

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.

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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 attendant 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.
- No Show Policy; Section (37.125(h)) of the regulations allows the provision of complementary paratransit service to be suspended for the following:
  - a. consistently misses scheduled appointments (does not apply to trips that are missed for reasons that are beyond the individual's control (scheduling problems, late pickups, and other operations problems).
- Scheduled appointments that are not cancelled will be reviewed by the Transportation Supervisor to determine if the service is being abused in which suspension of service may result.
- Applicant will be notified in writing of any suspension of 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 4<sup>th</sup>, Thanksgiving Day and Christmas Day.
- Fare: \$1.50 one way within the city limits; \$3.00 one way outside city limits
  1. Non ADA rider > same fare as ADA rider
  2. Personal Care Attendant > no charge





# 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 you 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?

\_\_\_\_\_

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

