New Application Effective December 1st, 2018

APPLICATION INSTRUCTIONS

Americans with Disabilities Act (ADA) | Paratransit Eligibility

All applicants must submit a complete application which includes **both forms**

1. **The Certification Questionnaire Form**
2. **The Professional Verification Form**

STEP 1 COMPLETE THE CERTIFICATION QUESTIONNAIRE

The **Certification Questionnaire** should be filled out by the applicant or the applicant's advocate. The form must be filled out in its entirety. It should be signed by the applicant or the applicant's guardian and anyone who assisted the applicant in completing the application.

The Professional Verification Form must be completed by one of the following professionals who are familiar with the applicant's condition:

STEP 2 COMPLETE THE PROFESSIONAL VERIFICATION FORM

- Physicians or Psychiatrists
- Occupational Therapists
- Psychologists
- Physical Therapists
- Licensed Clinical Social Worker (LCSW,LMSW)
- Speech/Language Pathologists
- Certified Orientation and Mobility Specialists
- Registered Nurses (RN)
- Doctor of Chiropractic (DC)

To complete the Professional Verification Form

1. Complete and sign the Authorization to Release Information.
2. Send the **Professional Verification** Form to your designated professional.
3. Wait for your professional to return the **Professional Verification** Form to you. Check back with your professional if you have not received the form back in a timely manner.

STEP 3 SUBMIT BOTH FORMS TOGETHER

Submit both the **Certification Questionnaire** and the **Professional Verification** Form in the **same envelope** to:

RVTD Accessible Transportation Dept.
239 E. Barnett Road
Medford, Oregon 97501

WE DO NOT ACCEPT APPLICATIONS BY FAX OR E-MAIL

See additional info on back

STEP 4 IN-PERSON ASSESSMENT

Typically, the forms provide RVTD with all the information needed to make a determination on eligibility. Sometimes however, more information is needed. When this happens, an applicant may be asked to come in for an **"in-person assessment"**.

This assessment may include:

- **A conversation about the applicant's current mobility.** The RVTD accessible transportation coordinator will talk with you about how you currently get around.
- **A walk inside or outside our administrative building.** This will help determine things such as physical ability to get to the regular fixed-route bus as well as memory and landmark recognition.
- **A standard walking and balance test.** This standardized test measures a person's risk of falling (Tinetti Gait and Balance Test).

PLEASE NOTE THAT APPLICANTS WHO NEED TO COME IN FOR AN IN-PERSON ASSESSMENT WILL STILL HAVE THEIR APPLICATION PROCESSED WITHIN 21 CALENDAR DAYS.

COMMON ISSUES

In order to make a determination within 21 calendar days, RVTD's Accessible Transportation Department must have a complete application. There are several things which may cause an application to be incomplete. By double checking these items PRIOR to submitting your application, you may avoid delays in processing.

1. **One of the forms is missing.** Your application must contain both the Certification Questionnaire and the Professional Verification. Please ensure both are submitted in the same envelope.
2. **One of the forms is not signed.** Both the Certification Questionnaire and the Professional Verification forms must be signed. If either the applicant or the professional forgets to sign the form, it is considered incomplete.
3. **The professional credentials are missing.** Professionals must include their titles and credentials when signing the Professional Verification.

Jane Doe X (Incomplete) **Jane Doe M.D. ✓ (Complete)** **Jane Doe R.N. ✓ (Complete)**

AN INCOMPLETE APPLICATION WILL BE RETURNED TO THE APPLICANT ONE (1) TIME. IF IT IS SUBMITTED A SECOND TIME AND IS STILL INCOMPLETE IT WILL BE HELD FOR 60 DAYS BY OUR ACCESSIBLE TRANSPORTATION DEPARTMENT BEFORE BEING DESTROYED.

APPLICATIONS MUST BE PROCESSED WITHIN 21 CALENDAR DAYS. IF YOUR PROPERLY COMPLETED AND SUBMITTED APPLICATION IS NOT PROCESSED WITHIN 21 DAYS, YOU WILL BE GRANTED PRESUMPTIVE ELIGIBILITY FOR VALLEY LIFT SERVICES UNTIL YOUR APPLICATION IS PROCESSED.

Questions? Please call 541.842.2080

CERTIFICATION QUESTIONNAIRE

Americans with Disabilities Act (ADA) | Paratransit Eligibility

1. See application Instructions
2. If you have additional questions call the RVTD Accessible Transportation Customer Service at (541) 842-2080 voice, 7-1-1 TTY.
3. This form is incomplete if it is NOT ACCOMPANIED BY COMPLETED PROFESSIONAL VERIFICATION.

WE DO NOT ACCEPT APPLICATIONS BY FAX

PART 1 APPLICANT DATA

Please print or type

Name:_____
First Middle Initial Last

Street Address:_____ Apt.#:_____

City:_____ Zip Code: _____

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

Email Address: _____

Birth Date:_____/_____/_____

I am a Veteran of the US Armed Forces. ____ Yes ____No

Mailing Address (if different from above)

Street Address:_____ Apt.#: _____

City:_____ Zip Code: _____

Emergency Contact Person

#1: Name: _____
First Last Relationship

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

#2: Name: _____
First Last Relationship

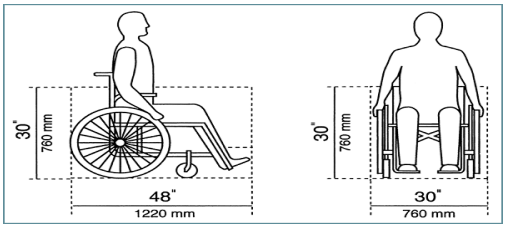
Day Telephone: ( )_____ Evening Telephone: ( ) _____

By providing emergency/alternate contact numbers, you authorize RVTD or its representatives to contact the individuals listed regarding your Paratransit service.

Office Use Only

Client ID #	*Exp. Date*	*Category*	*PCA*	*Svc Animal*	*Notes*
		1 3	*Y N*	*Y N*	

1. **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 device and occupant more than 600 pounds? ____Yes ____No

2. **Which of the following assistive devices, if any, do you use:** *(please check all that apply)*

☐ Cane	☐ Manual Wheelchair	☐ Boarding Chair	☐ Prosthesis
☐ White Cane	☐ Powered Wheelchair	☐ Service Animal	☐ Communication Aid
☐ Walker	☐ Powered Scooter	☐ Portable Oxygen	☐ Crutches
☐ Cart	Other: _____		

3. **Do you need to travel with a Personal Care Attendant (PCA)?** *A PCA is someone designated or employed specifically to assist you meet your personal needs. RVTD cannot provide you a PCA and our drivers cannot serve as your PCA. (select one)*

   ☐ **No** – You may still have someone travel with you whenever you wish
   ☐ **Sometimes** – you travel with a PCA at your own discretion
   ☐ **Yes** – You cannot travel alone and always need to travel with a PCA.

4. **Does your health condition/disability require you to use RVTD's Valley Lift service:**
   ☐Seasonally (Nov. - Apr.) ☐Temporarily *
   ☐Permanently
   * If temporarily, for how long? _____ Week(s) _____ Month(s)

5. **Does your health condition/disability change from day to day in ways that occasionally disrupts your ability to use fixed-route bus service?** _____Yes _____No

   If yes, please explain: _____

PART 2 QUESTIONS ABOUT USING FIXED-ROUTE PUBLIC TRANSIT

Complete Part 2 even if you are unable to use fixed-route bus service. This information will assist us in determining how your disability/health condition affects your ability to use fixed-route bus service.

1. **Do you now independently use fixed-route bus service?** _____Yes ____No _____Sometimes

   If "Yes" or "Sometimes," how many times? _____per week _____per month _____per year

   Which of the following best describes how you use fixed-route bus service?
   ☐ 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 fixed-route bus service.

   _____

   _____

2. **Have you ever had training to use the fixed-route bus service?** _____Yes _____No

3. **What accommodations would assist you in using RVTD's fixed-route bus service?**

____ Route & Schedule Information
____ Accessible bus stop and pathway
____ No Transfers
____ Other _____
____ Bus stops closer to home/destination
____ Bench/Shelter at bus stop
____ Training to use the fixed route bus

4. **Using a mobility aid or on your own, how far are you able to travel without the assistance of another person?** ☐1 block ☐3 blocks ☐6 blocks or more ☐less than 1 block

5. **I can wait for a fixed-route bus service: (check all thatapply):**

___ Only if there is a bench
___ Up to 15 minutes
___More than 15 minutes
___My disability prevents me from waiting for any period of time*

*Please explain:_____
_____

6. **Please check all the categories below as they relate to your ability to use fixed-route bus service:**

	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 recognize printed information	☐	☐	☐
F.	Able to hear and process spoken words or auditory information	☐	☐	☐
G.	Able to communicate needs	☐	☐	☐
H.	Able to follow directions	☐	☐	☐
I.	Able to deal with unexpected situations or changes in routine (example: bus detours)	☐	☐	☐
J.	Able to safely and effectively travel through crowded and/or complex facilities	☐	☐	☐
K.	Able to recognize changes in terrain	☐	☐	☐
L.	Able to travel independently along sidewalks and other pedestrian ways	☐	☐	☐
M.	Able to cross streets independently	☐	☐	☐
N.	Able to find the correct bus stop	☐	☐	☐
O.	Able to identify the correct bus	☐	☐	☐
P.	Able to get on and off a bus using the lift if necessary	☐	☐	☐
Q	Able to deposit fare into the fare box or show bus pass	☐	☐	☐
R	Able to get to a seat/wheelchair position and remain seated during a bus trip	☐	☐	☐
S.	Familiar with what to do if I miss my bus	☐	☐	☐

If you checked “No” or “Sometimes” to any of the items in question 6, please explain below:

_____

_____

_____

PART 3 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, visual or locational information pertaining to application for or users of ADA paratransit service is private. No information related to RVTD’s Accessible Transportation Services can be released to anyone else, unless the applicant or user authorizes the release in writing.

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: *(please print)* _____
First Last Relationship

Contact Phone: ( ) _____

Guardian’s Signature: _____ Date:_____/_____/_____

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

Name: *(please print)* _____
First Last Relationship

Contact Phone: ( ) _____

Preparer’s Signature:_____Date:_____/_____/_____

ELIGIBILITY APPLICATION PROFESSIONAL VERIFICATION

Americans with Disabilities Act (ADA) | Paratransit Eligibility

1. **Complete and sign** the "Authorization to Release Information".
2. **Send** to your designated medical professional.
3. **Wait** for your medical professional to return this form to you.
   Check back with your medical professional if you don't receive your information.
4. **This form is incomplete if it is NOT ACCOMPANIED BY COMPLETED CERTIFICATION QUESTIONNAIRE.**

WE DO NOT ACCEPT APPLICATIONS BY FAX

PART 3 APPLICANT SIGNATURE

PLEASE PRINT OR TYPE

(WHEN COMPLETE SEND TO THE PROFESSIONAL YOU NAMED)

Applicant's Name: _____
First Middle Initial Last

Birth Date:_____/_____/_____

Applicant's Address:_____Apt.#:_____

City:_____State:_____ Zip Code: _____

Applicant's TelephoneNumber ( ) _____

I authorize the following professional to release to RVTD 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 B 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 para-transit 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. RVTD Accessible Transportation staff makes the final determination on
eligibility status.

THIS SECTION MUST BE FILLED OUT FOR ALL APPLICANTS

GENERAL INFORMATION

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

_____

· Describe any other health conditions or disabilities with which this individual is diagnosed: _____

_____

· Date of onset _____/_____/_____

· Date of last visit _____/_____/_____

· How long have you worked with the individual? Since _____/_____/_____

· Is their disability temporary_____or permanent_____?

If permanent, is their disability progressive? _____Yes _____No

If temporary, please give best estimate of rate of recovery. _____

· Do temperature extremes affect the individual?

(Ex. Heat index of more than 85 degrees or wind chill less than 10 degrees)_____Yes____No
If yes, how so? _____

· Does the individual currently use regular fixed-route public transportation?____Yes _____No _____Not Sure

· Is the individual's judgment impaired? _____ Yes _____No

· Is behavioral inhibition impaired?_____Yes _____No

· Can the individual walk? _____Yes _____No

· Does the individual use a mobility aid?_____Yes_____ No Please list: _____

_____

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

_____

· How far can the individual travel without the assistance of another person?

☐ 1 block ☐ 3 blocks ☐ 6 blocks or more ☐ less than 1 block

· With treatment/therapy will this distance increase? _____Yes_____ No

· Please indicate the expected distance after treatment/therapy:

☐ 1 block ☐ 3 blocks ☐ 6 blocks or more ☐ less than 1 block

Give best estimate of length of time required to achieve this improvement.

_____

PLEASE COMPLETE ONLY THOSE SECTIONS THAT APPLY TO THIS INDIVIDUAL

NEUROLOGICAL IMPAIRMENT/HEAD INJURY

· Does the individual experience seizures?_____Yes_____No

· Please give no. of seizures_____ and frequency _____

· What type(s) of seizures does patient experience? _____

· 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 places on time

· Is there history of Brain Injury _____Yes _____No

VISUAL IMPAIRMENT

· Select all the describes this individual's visual disability:

☐ Totally Blind ☐Night Blindness ☐Severely Blurred/Distorted Vision ☐Tunnel Vision ☐Loss of Depth

☐ Other _____

· Does the individual require any accommodations, adaptations, low vision aids, etc.? Please list:

_____

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

_____

· Has the individual received any orientation & mobility (O&M) training? _____Yes _____No

COGNITIVE/MENTAL IMPAIRMENTS

- Does the individual experience any of the following:

  ☐ Auditory hallucinations ☐ Visual hallucinations ☐ Delusions ☐ Disassociation

- 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 panic attacks.

  Per day _____Per week _____Per month _____Per year _____

  Approx. duration: _____

- 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 the individual able to live independently? _____Yes _____No
- Can the individual be left alone? _____Yes _____No _____ *Sometimes

  *Please explain: _____

Additional Comments: _____

_____

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

Name of Professional:_____Date:_____/_____/_____

Title: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: ( ) _____ Fax: ( ) _____

☆ **Doctor/Health Care Professional Signature:** _____

**Form must be signed with credentials to be valid.*