



NFTA Special Services/Paratransit  
181 Ellicott Street  
Buffalo, New York 14203

Dear Applicant,

Thank you for your interest in the NFTA-Metro paratransit service for people with disabilities. Enclosed is an application packet including:

1. Application Instructions
2. Part I-Application
3. Part II-Application (Professional Verification)
4. Authorization to Disclose Medical Information to Paratransit Access Line

NFTA Paratransit Access Line (PAL) is a shared ride service that provides origin-to-destination transportation for paratransit eligible individuals under the Americans with Disabilities Act (ADA). To qualify for PAL you must have a temporary or permanent disability and are unable to get on, ride, or get off an accessible Metro bus or rail vehicle, or travel to or from a bus stop/rail station, some of the time or all of the time.

You may be able to access buses operating on fixed routes. Accessible buses have equipment (including wheelchair ramps) to assist individuals with disabilities. Bus operators are required to make bus stop announcements. Metro Rail service is ADA compliant and therefore accessible to individuals with disabilities.

If you have any questions about the application, the review process or require information in alternative format, please contact Paratransit Access Line at (716) 855-7268 or 1-800-662-1220 or 711 (TDD/Relay).

## APPLICATION INSTRUCTIONS

**Step 1:** Read the entire application and answer all questions contained in Part 1 of the application. Questions requiring explanations should be brief, but accurate. **Failure to answer any questions will delay processing your application.** Part 1 can be completed by you alone or with the assistance of another person.

**Step 2:** When you have completed Part 1, forward the entire application (Parts 1 & 2), to a qualified health professional (refer to list below). Part 2 must be completed by a licensed or certified health care professional who is currently treating you for your disability, or a licensed or certified health care or rehabilitation professional who you visit for a paratransit evaluation, and whose title is listed below. One of the following professionals must complete Part 2 of the application.

- Physical or Occupational Therapist
- Certified Rehabilitation Counselor
- Licensed Social Worker
- Certified Case Manager -Commission for Case Manager Certification (CCMC)
- Psychiatrist *Physical Medicine and Rehabilitation (PM&R)*
- Orientation and Mobility Specialist
- Qualified Intellectual Disability Professional, QIDP

**Step 3:** Upon completion of both Part 1 and Part 2, mail the application to:

**NFTA Special Services/Paratransit  
181 Ellicott Street  
Buffalo, New York 14203**

**You will be advised of your eligibility status in writing no later than 21 days after our receipt of both parts of your fully completed application.**

If you are denied eligibility, the reason for the denial and procedures to appeal the denial of eligibility will be detailed in that letter.

Your eligibility will be carefully determined through a certification process in compliance with the regulations of the Americans with Disabilities Act of 1990. An accurate determination depends on the answers and information provided by you. Inaccurate or false information may lead to denial or suspension of service.

If you have any questions about the application, the review process or require information in alternative format please contact Paratransit Access Line, at (716) 855-7268 or 1-800-662-1220 or 711 (TDD/Relay).



**PART 1**  
**APPLICATION FOR PARATRANSIT SERVICE**  
**TO BE COMPLETED BY THE APPLICANT**

New Application

Renewal Application

**PERSONAL INFORMATION**

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Number Street Apt. #

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Alternate Mailing Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Month/Day/Year last four digits

*Please answer all questions in detail, your specific answers will assist us in determining your eligibility for Paratransit Access Line (PAL) service. Information on this form will be used for the sole purpose of determining eligibility for PAL. The information that you provide will be kept strictly confidential.*

**DISABILITY INFORMATION**

1. Please describe any physical, mental, visual or cognitive disabilities, which **prevent** you from using the fixed route bus system. \_\_\_\_\_

2. How does this disability prevent you from boarding, riding, exiting or navigating the NFTA fixed route bus/rail system without the help of another person? Be specific. \_\_\_\_\_

(Please attach any additional documentation which you feel will support your inability to travel to and from a boarding or disembarking location, or to board, ride or exit a fixed route bus.)

3. Are the conditions you described:  permanent  temporary  
If temporary, how long do you expect to have this disability? \_\_\_\_\_

## MOBILITY INFORMATION

4. Can you walk/travel 200 feet without the assistance of another person?

- Yes  No  Sometimes

Can you walk/travel ¼ mile (2 to 4 city blocks) without the assistance of another person?

- Yes  No  Sometimes

Can you walk/travel ¾ mile (6 to 8 city blocks) without the assistance of another person?

- Yes  No  Sometimes

Can you climb three 12-inch steps without assistance?

- Yes  No  Sometimes

Can you wait outside without assistance or support for ten minutes?

- Yes  No  Sometimes

Can you deposit your fare independently?

- Yes  No  Sometimes

5. Where is the closest bus stop to where you live? \_\_\_\_\_

6. How far is this stop from where you live?

- Within a city block  ¼ mile  1/2 mile  
 ¾ mile  unsure

7. Does weather impact your ability to travel?

- Yes  No

If yes, please explain how weather conditions impact your ability to ride the fixed route bus/rail system. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Which of these mobility aids or equipment do you use to get where you need to go?

(Please check all that apply)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> motorized wheelchair          | <input type="checkbox"/> manual wheelchair | <input type="checkbox"/> powered scooter |
| <input type="checkbox"/> Personal Care Attendant (PCA) | <input type="checkbox"/> walker            | <input type="checkbox"/> cane            |
| <input type="checkbox"/> crutches                      | <input type="checkbox"/> service animal    | <input type="checkbox"/> white cane      |
| <input type="checkbox"/> portable oxygen               | <input type="checkbox"/> prosthesis        |  |

## TRAVEL INFORMATION

9. Do you currently ride a Metro fixed route bus/rail independently?  
 Yes  No  Sometimes

10. Have you ever received training or instruction to learn how to use the Metro bus system?  
 Yes  No

If yes, when and where: \_\_\_\_\_  
\_\_\_\_\_

If you completed this training and are able to use certain bus routes, please list them below:

\_\_\_\_\_  
\_\_\_\_\_

If available, would you like to receive training or retraining to learn how to use the fixed-route buses or rail cars?

- Yes  No

11. Do you require someone to accompany you to travel outside the home, for example, a Personal Care Attendant (PCA)?  
 Yes  No  Sometimes

If you answered yes or sometimes to needing someone to accompany you to travel outside the home, what type of assistance does the person provide?

- Help me get to and from the bus/rail station  
 Help me get on and off the bus/rail station  
 Help me while I ride the bus/rail  
 Other: \_\_\_\_\_  
\_\_\_\_\_

12. How do you currently travel?  
 Van Service(s)  Agency Transportation  
 NFT Metro Bus/Rail  Passenger in someone's vehicle  
 Taxi  
 Other: \_\_\_\_\_

*I hereby affirm that the information given above is true and correct. I expressly acknowledge that the NFTA will rely on the information in making a determination as to my eligibility to participate in this program. I understand that falsifying information or providing misleading information may result in denial of service. I authorize the completion of this form and/or the release of related information to NFTA, Special Services Department.*

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Signature of Applicant

Date

**If someone other than the applicant completed this form on behalf of the applicant, that person must complete the following:**

Printed Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

*I affirm that the information provided in this application is true and correct based on information given to me by the applicant and/or based on my own knowledge of the applicant's disability. I have the authorization to complete this form on behalf of the applicant.*

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Signature

Date

Please enclose a recent photograph of yourself to be used on your Paratransit identification card.  
Photo will be returned if you are denied.

NFTA Special Services/Paratransit  
181 Ellicott Street  
Buffalo, New York 14203  
716-855-7268



## APPLICATION FOR PARATRANSIT SERVICE PROFESSIONAL VERIFICATION

Dear Healthcare Professional:

You are being asked by \_\_\_\_\_, (applicant) to provide information regarding his/her ability to use our transit services. Federal law requires that NFTA provide Paratransit services to persons who cannot use fixed-route transit services. The information you provide will allow us to evaluate this request and its application to specific trip requests. ***Please provide complete and specific information to describe how the applicant's functional abilities prevent them from using NFTA Metro and how the diagnosis impacts that ability.*** In the event you must disclose protected health information about the applicant, we have provided the applicant with an Authorization to Disclose Protected Health Information and asked them to provide an executed copy to your office with this application. Thank you for your cooperation in this matter.

Eligibility for PAL is strictly limited. A person may be eligible for PAL if, due to a physical, visual or mental disability they:

- cannot independently board, ride or exit from any vehicle on the fixed route bus or rail system which is accessible and usable by individuals with disabilities.
- cannot use an accessible fixed route vehicle, but the route or the accessible vehicle on the route that would be used is not accessible or usable, or the stop that would be used is not accessible or usable due to the physical characteristics of the stop.
- cannot independently travel to or from the fixed route bus stop or rail station.

***PLEASE NOTE:*** *This does not include persons who find it uncomfortable or difficult to get to and from bus stops. Paratransit is for individuals whose disability prevents them from using public transportation. All of our vehicles are equipped with a ramp or wheelchair lift for individuals who use a wheelchair or are unable to climb stairs.*

Resources for this program are limited and your evaluation of each person must be based solely upon the individual's ability to use regular transit service. 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 program. False verification could result in travel limitation for persons legitimately qualified to use the program.

## CERTIFICATION PROCESS

1. Applicant (or representative) has completed Part 1. Please read Part 1 in its entirety.
2. Health care professionals completing Part 2 must be guided by the criteria explained herein.
3. NFTA may contact the certifying health care professional to verify the accuracy of the information.
4. NFTA will make the final determination as to the applicant's eligibility.
5. The application must be filled out COMPLETELY for processing to occur.

Metro PAL is public transportation service for disabled persons who, because of a mental, physical or visual impairment or disability, find it IMPOSSIBLE to use regular public transportation. **All parts must be completely filled out by the authorized person who signs below.** (*Incomplete forms will be returned to the applicant and/or healthcare professional*)

If you have any questions about the Application or the review process, please contact Paratransit at (716) 855-7268.

Thank you,

Patricia B. Wiseman  
Superintendent of Special Services

NFTA Special Services/Paratransit  
181 Ellicott Street  
Buffalo, New York 14203



**PART 2**  
**APPLICATION FOR PARATRANSIT SERVICE**  
**PROFESSIONAL VERIFICATION**

Applicant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

*This part of the application form **must be completed by one of the following professionals** who is currently treating the applicant for the disability, or one of the following professionals who will complete the application for the sole purpose of evaluating how the disability affects functional mobility.*

**Please identify your professional area of specialization**

- Physical Therapist
- Occupational Therapist
- Licensed Social Worker
- Certified Rehabilitation Counselor
- Certified Case Manager
- Orientation and Mobility Specialist certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP) or the National Blindness Professional Certification Board.
- Qualified Intellectual Disability Professional, QIDP
- Psychiatrist Physical Medicine and Rehabilitation (PM&R)

**DISABILITY INFORMATION**

1. In what capacity do you know the applicant and for how long? \_\_\_\_\_  
\_\_\_\_\_
2. Is the applicant your regular client?            Yes            No
3. Please list the *medical diagnoses* of all disabilities which functionally prevent the applicant from:
  - a. getting to or from a Metro bus stop or rail station
  - b. boarding or disembarking an accessible Metro bus or rail car
  - c. riding or navigating an accessible Metro bus/rail\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Is the disability:
  - permanent
  - temporary, timeframe you anticipate the applicant to recover \_\_\_\_\_ (e.g. 6 months)Is the condition likely to worsen?            Yes            No

## MOBILITY INFORMATION

5. Does the applicant have additional contributing visual and/or mental conditions that prevent travel?  
 Yes       No
6. Under which category below is the applicant applying for eligibility to utilize NFT Metro Paratransit service. **Check all that apply**
- Non-Ambulatory Disability
  - Mobility Aid
  - Arthritis
  - Amputation
  - Cerebrovascular Accident
  - Pulmonary Ills
  - Cardiac Ills
  - Dialysis
  - Disability of Incoordination
  - Cerebral Palsy
  - Epilepsy
  - Visually Impaired/Blind
  - Cognitive
7. Which statement best describes the applicant's need for Paratransit Services?  
**(Check all that apply)**
- Has a severe physical, mental, or visual disability which makes it *impossible* to use the NFT Metro accessible Bus/Rail system under any circumstances.
  - Has a mobility problem which prevents the applicant from boarding an accessible vehicle without the assistance of a personal care attendant.
  - Has a mental or visual impairment which prevents him/her from remembering & understanding all the applicant must do to find their way to and from a NFT Metro bus/rail stop and ride the system.
8. Which one of the following applies to the applicant?
- The applicant will never have the ability to learn how to use the NFT Metro System even with mobility training.
  - With mobility training the applicant is capable of learning how to use the NFT Metro System.
  - The applicant can use the NFT Metro Bus/Rail system sometimes, but for certain trips the individual has not been trained or there are other barriers present.

9. In your opinion, under which of the two circumstances described in the ADA, Section 37.123(e) does the applicant qualify for paratransit service? **(please check one)**

**Any individual with a disability who is unable, as the 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.

Yes       No

**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.

Yes       No

10. Does the applicant require any of the following mobility aids? **(Please check all that apply)**

*\*NOTE: If it is indicated that the applicant uses a wheelchair or scooter for mobility you must supply the dimension and combined weight. Dimension cannot exceed **30 inches** in width and **48 inches** in length measured two inches above the ground, and does not weigh more than **800 pounds** when occupied.*

	Yes	No	Sometimes	Width	Length	Combined weight
Manual wheelchair*	_____	_____	_____	_____	_____	_____
Motorized wheelchair*	_____	_____	_____	_____	_____	_____
Scooter*	_____	_____	_____	_____	_____	_____
Cane, crutches, or walker	_____	_____	_____			
Service animal	_____	_____	_____			
Personal Care Attendant	_____	_____	_____			
Sighted guide/escort	_____	_____	_____			
Oxygen	_____	_____	_____			

11. Can the applicant make paratransit travel reservations and/or cancellations independently?

Yes       No

12. Is the applicant able to:

Give addresses and telephone numbers upon request?  Yes     No

Recognize a destination or landmark?  Yes     No

Sign his/her name?  Yes     No

Deal with unexpected situations and changes in routine?  Yes     No

Ask for, understand, and follow directions?  Yes     No

Count money and pay fare?  Yes     No



I have read Part 1 of this application in its entirety. (Submitted by applicant)

Yes  No

I agree with the information contained in Part 1 as provided by the applicant.

Yes  No

If no, please explain and provide specifics for each question you disagree with in Part 1. You may attach an additional sheet if needed.

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

Name: \_\_\_\_\_

Office Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Office Phone: \_\_\_\_\_

New York State License/Certification Number: \_\_\_\_\_ (MUST PROVIDE)

(QIDP) Qualified Intellectual Disability Professional

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Professional's Signature)

Specialty or Title & Agency: \_\_\_\_\_

**Please return this completed form along with Part 1 (previously completed by applicant) to:**

**NFTA Special Services/Paratransit  
181 Ellicott Street  
Buffalo, New York 14203**

AUTHORIZATION TO DISCLOSE  
PROTECTED HEALTH INFORMATION

I hereby authorize \_\_\_\_\_, (insert Health Care Professional's Name) entrusted with handling medical records to disclose to the NFT Metro all of the protected health information relating to \_\_\_\_\_ (insert the applicant's name), to fully and accurately complete the NFT Metro Application for Paratransit Service which the application will be used by NFT Metro for determining whether the Applicant is eligible for Paratransit Access Line (PAL).

This authorization shall remain in effect until the Applicant's eligibility for PAL service is finally determined or sixty (60) days, whichever is shorter.

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Health Care Professional that would be completing Part II of this application. I understand that the revocation of this authorization is not effective to the extent that the Health Care Professional has relied upon it for the use or disclosure of the Protected Health Information prior to receiving written revocation notice.

I understand that any Protected Health Information disclosed pursuant to this Authorization to an individual or entity that is not covered by the state and federal privacy laws and regulations may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient (or Personal Representative)

**Important:** If a Personal Representative signed above, please describe his or her relationship with the patient (e.g., parent) or other authority to sign this form on the behalf of the patient (e.g., legal guardian): \_\_\_\_\_