NFTA Paratransit & Mobility Services
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 1-Application
3. Part 2-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. <u>One of the following professionals must complete Part 2 of the application.</u>

- Physical Therapist
- Occupational Therapist
- Certified Rehabilitation Counselor
- Licensed Social Worker
- Certified Case Manager -Commission for Case Manager Certification (CCMC)
- Physiatrist *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 Paratransit & Mobility Services
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 <u>both parts of your fully completed application.</u>
If an eligibility determination is not made within 21 days, you are treated as eligible and can use PAL service, until and unless your application is denied. Please contact at 716-855-7268, TTY:711

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).

NFTA-METRO
Serving Buffalo Niagara

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 Sec.#: {last four digit}_____
Month/Day/Year

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
❑3/4 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)
❑ motorized wheelchair ❑ manual wheelchair ❑ powered scooter
❑ Personal Care Attendant (PCA) ❑ walker ❑ cane
❑ crutches ❑ service animal ❑ white cane
❑ portable oxygen ❑ 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)
    ❑ NFT Metro Bus/Rail
    ❑ Taxi
    ❑ Other: _____
    ❑ Agency Transportation
    ❑ Passenger in someone's vehicle

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, Paratransit & Mobility Services Department.

_____

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.

_____ _____

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 Paratransit & Mobility Services
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 using NFTA Metro fixed route bus/rail 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, are prevented from using Metro fixed route services. **All parts must be completely filled out by the authorized person who signs Part 2.** ***(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,
Paratransit & Mobility Services
Niagara Frontier Transportation Authority

NFTA Paratransit & Mobility Services
181 Ellicott Street
Buffalo, New York 14203

NFTA-METRO
Serving Buffalo Niagara

PART 2
APPLICATION FOR PARATRANSIT SERVICE
PROFESSIONAL VERIFICATION

Applicant Name: _____ Date of Birth: _____

*This part of the application **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 (within the scope of practice and knowledge) will evaluate 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 -Commission for Case Manager Certification (CCMC)
- ❑ 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
- ❑ Physiatrist 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

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

Travel 200 feet
❑ Yes ❑ No ❑ Sometimes

Travel ¼ mile (2 to 4 city block)
❑ Yes ❑ No ❑ Sometimes

Travel ¾ mile (6 to 8 city blocks)
❑ Yes ❑ No ❑ Sometimes

Can you climb three 12-inch steps without assistance?
❑ Yes ❑ No ❑ Sometimes

Can the applicant wait outside without support for 10 minutes?
❑ Yes ❑ No ❑ Sometimes

14. Does the applicant exhibit disruptive behavior under certain circumstances? ❑ Yes ❑ No

If yes, would this behavior endanger him/her or other passengers? ❑ Yes ❑ No

If yes, please describe what types of conditions are likely to cause such behavior. _____

_____

_____

_____

15. **Please describe in detail** the circumstances under which you believe the applicant could **not** independently access NFT Metro bus/rail service?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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.

_____

_____

_____

_____

_____

_____

_____

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 Paratransit & Mobility Services
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): _____