# City of Helena, Capital Transit Bus Service (CT)
# Transit Functional Needs Evaluation
# For ADA Complementary Paratransit Service

**Final 12/20/13**

Thank you for inquiring about eligibility for the ADA Complementary Origin to Destination Paratransit bus service. Enclosed is a copy of our Transit Functional Needs Applicant Form, Release of Medical Information Form, and a Healthcare Professional Verification of Disability Form.

**Please read these instructions before completing the application form.**

## What is the ADA Complementary Origin to Destination / Paratransit Service?

The American with Disabilities Act (ADA) is a Federal law that protects the passenger's right to accessible public transportation. City of Helena, Capital Transit provides ADA complementary Origin to Destination / paratransit service within ¾ of a mile of the fixed route for passengers who are unable to use the fixed route bus stops due to a qualifying disability. To use this service the passenger must be eligible. To determine eligibility, passengers must complete all parts of the City of Helena, Capital Transit Functional Needs Evaluation application.

**While your application is being reviewed you will be issued a temporary paratransit eligibility card.**

**Types of Eligibility for Functional Needs Paratransit Service.**

If you are determined eligible for ADA Complimentary Origin to Destination/Paratransit Service, you will receive one of the following types of eligibility:

**Conditional Eligibility:** You are able to use the Fixed Route Bus Stops for some of your trips and qualify for ADA Complementary Origin to Destination/Paratransit Service for other trips as determined.

**Unconditional Eligibility:** Your disability or health condition **always** prevents you from using the Fixed Route Bus Stops and you qualified for ADA Complementary Origin to Destination/Paratransit Service for **all** of your trips.

**Temporary Eligibility:** You have a health condition or disability that temporarily prevents you from using the Fixed Route Bus Stops and allows you to use the ADA Complementary Origin to Destination/Paratransit Service.

**How Do I Apply?**

Two forms and a medical release are enclosed that must be filled out completely and returned to Capital Transit at the address below. The Transit Functional Needs Applicant form is for you or your caregiver to complete in order to provide us with the information we need to evaluate your application. If you require assistance completing the Transit Functional Needs Evaluation Applicant form please contact Capital Transit at (406) 447-8080 or (406) 447-8081 and schedule you an appointment to come in and we will assist you with completing the form. The second form, the Health Care Verification of Disability form is to be completed by your Healthcare professional who is able to verify the information on your application and provide additional information about how your disability prevents you from using the regular fixed route transit service. Before taking the form to your Healthcare professional, you should complete and sign the Authorization to Release Medical Information form provided. Once ALL information on both forms is completed and the medical release has been signed, please mail or fax the forms to the following address:

City of Helena
ATTN: Capital Transit
1415 North Montana Ave.
Helena, MT. 59601
FAX 406-447-8063

**As the applicant, you are responsible for submitting all of the documents to determine your eligibility to use the ADA Complementary Origin to Destination/Paratransit bus service.**

1. **All questions must be answered.** Incomplete and/or unsigned forms will not be accepted and may cause a delay in your eligibility review. Applications must be submitted on the healthcare professional's official letterhead or on the Healthcare Professional Verification of Disability Form provided.

2. **Completed applications will be processed within 21 working days of receipt.** You will be notified by letter of your eligibility determination for the paratransit service. If you have not been notified with working 21 days, please call and we will provide you with Functional Needs Paratransit Services until your application is processed and a final determination of eligibility is determined.

**Having a disability does not necessarily qualify you for Paratransit Service.** Your disability MUST affect your ability to board, ride and get off an accessible Fixed Route Bus. The Capital Transit, transit provider reserves the right to make the final determination.

The information you provide is confidential. Your information will only be shared with other transit agencies involved with the City of Helena- Capital Transit. Your information will not be provided to any other person or agency, except as provided by the Montana Open Records Act.

*Please note: it is your responsibility to notify us if your disability improves enough to change your eligibility status. If your condition improves after you have been determined eligible or we discover that you submitted false information, your eligibility could be suspended or you may be asked to re-apply.*

**If you have any questions, please contact the**
**City of Helena, Capital Transit Operations Coordinator**
**(406) 447-8067**

# City of Helena - Transit Functional Needs Applicant Form

We are requesting this information in order for Capital Transit to customize your transit needs.
This information will not be shared or discussed with any other person or agency except your Health Care Professional.

**Incomplete forms will be sent back to you. This will delay the certification process.**

**□ NEW APPLICATION Date_____ □ RECERTIFICATION Date _____**

**General Information (PLEASE PRINT OR TYPE)**

Last Name _____First Name _____ MI ____

Address: _____Apt# _____

City _____ State _____ Zip _____

Telephone: Home (____) _____ Work (____) _____Cell (____) _____

Date of Birth _____/_____/_____ Sex: □ Male □ Female

Address where Capital Transit will pick you up, if different from above:
_____

**Emergency Contact**:

Name: _____ Relationship: _____

Telephone: Home (____) _____ Work (____) _____ Cell (____) _____

Did someone assist you in filling out this form? Yes □ No □

Should this person be contacted if additional information is needed? Yes □ No □

Name: _____ Relationship: _____

Address: _____Apt# _____

City _____ State _____ Zip _____

Telephone: Home (____) _____ Work (____) _____Cell (____) _____

# INFORMATION ABOUT YOUR FUNCTIONAL ABILITIES

1. Please indicate the reason(s) why you are seeking ADA Complimentary Origin to Destination/Paratransit Service: (Check all that apply):
   - ☐ The closest fixed route bus stop is too far from my home (more than 1300').
   - ☐ I do not know how to ride the fixed route bus.
   - ☐ I am unable to get or remember transit system information.
   - ☐ I cannot walk by myself between the bus stop and my destination because of the (check all that apply):
     - Up/down curb cuts hinder me
     - Various terrains hinder me
     - Cross streets of various widths hinder me
     - Various street signal controls stop me
   - ☐ I am afraid to use the fixed route bus.
   - ☐ I am unable to calculate the correct fare.
   - ☐ I am unable to put the fare in the fare box.
   - ☐ I cannot recognize where to exit the bus.
   - ☐ I do not want to use the route bus.
   - ☐ Other (explain) _____
     _____

2. Do you use any of the following mobility aids or specialized equipment? (Check all that apply):

| | | |
|---|---|---|
| ☐ I do not use any mobility aids | ☐ Cane | ☐ White Cane |
| ☐ Motorized Wheelchair | ☐ Walker | ☐ Scooter |
| ☐ Manual Wheelchair | ☐ Leg Braces | ☐ Crutches |
| ☐ Respirator/portable Oxygen tank | ☐ Service Animal | ☐ Other _____ |

3. What assistance/support if any, do you need to safely ride the fixed route bus? _____
   _____

4. Can you find a seat by yourself without assistance of another person?
   - ☐ Yes
   - ☐ No

5. What is your ability to handle unexpected situations?
   - ☐ I cannot handle unexpected situations.
   - ☐ I have the ability to handle some unexpected situations.
   - ☐ I have the ability to most unexpected situations.

## Certification of Application

I hereby certify that, to the best of my knowledge, information given in the application is correct. I understand that the application will be returned if it is not completed. I further understand that the results of this review will be based on my ability to use the regular bus (Fixed Route) transportation and may require additional information from me, such as additional consultation from my physician or other healthcare professional. I understand that providing false information and/or failure to adhere to the policies and procedure for using an ADA Complimentary Origin to Destination/Paratransit Service may be grounds for suspension or revoking my eligibility to participate in this program.

Applicant's Signature_____Date____/____/____

**Please review each of your answered questions to make sure that you have completed all of the questions to the best of your ability as incomplete and/or unsigned forms will not be accepted an may cause delay in your eligibility.**

Name of person completing the application for Capital Transit Paratransit Service if someone other than the applicant:

Name:_____

Address:_____

City, State, Zip:_____

If you have any questions, please contact the City of Helena, Capital Transit Operations Coordinator at (406) 447-8067.

# Release of Medical Information Authorization Form

**(Must be signed by applicant or legal representative)**

Name of Applicant (please print):_____

Signature of Applicant or legal representative:_____

Address:_____

Date:_____

Phone number:_____

By signing this form, the applicant or legal representative authorizes a healthcare professional to release ADA eligibility and verification information. Verification about the applicant's disability and travel abilities will be used to evaluate his or her eligibility to receive ADA Comparable Para-transit Service. **This eligibility is valid for two (2) years from authorization date.**

**Healthcare Professional:**

The above identified individual is applying for Capital Transit Paratransit Service. In accordance with ADA guidelines, Paratransit service is available only for persons who have disabilities that prevent them from taking fixed route buses. The individual could be prevented by inabilities to independently get to and from a bus stop, on or off a bus, or successfully navigate to a destination from the stop. Please keep in mind that the Americans with Disabilities Act (ADA) Paratransit eligibility, is not based on age, a medical condition, inability to drive, or the use of a particular mobility aid. The severity of a disability does not confer eligibility. ADA Paratransit eligibility is based on the EFFECT that a disability has on individuals ability to use the Capital Transit lift and ramp equipped fixed route bus system and its stops.

**Please note: The term, *Healthcare Professional* refers to the any of the following: Medical Doctors, Registered Nurses, Social Workers, Independent Living Specialists, Occupational Therapists, Psychiatrists, Psychologists, Physical Therapists, Rehabilitation Specialists, Audiologists, and Ophthalmologists. If your health care professional is not listed please contact Capital Transit for further information.**

# Health Care Professional Verification of Disability Form

1. Have you ever examined/evaluated the applicant in the past? Yes □ No □
   If yes, was the examination/evaluation within the last twelve months? Yes □ No □

2. What is the applicant's specific disability or health condition/limitation and how does it limit or prevent his/her ability to travel independently or utilize the City of Helena, Capital Transit fixed route service?

   _____
   _____
   _____

   **(This section is used to determine applicants need for the ADA Complimentary Origin to Destination/Paratransit Service.)**

   Examples of disabilities or health condition:
   - Certified Legally Blind
   - Loss or inability to use one or more limbs
   - Severe effects of stroke
   - Paralysis affecting mobility, speech, vision or memory
   - Severe Arthritis
   - Autoimmune disorders, for example, Lupus or Scleroderma
   - Severe cardiac and/or respirator impairment affecting strength and/or endurance
   - Developmental disabilities, for example, mental retardation, cerebral palsy, epilepsy, Autism or neurological disorder, etc.
   - Hearing loss accompanied by an inability to understand speech with/without a hearing Aid.
   - Other (***Please explain the medical diagnosis and then describe the disability or health Condition/limitation). Use other side of page if necessary.***

   _____
   _____
   _____

3. Is the applicant's disability:
   Permanent Yes □ No □
   If no, how long will the individual be temporary disabled? _____

4. What mobility aids does the applicant utilize? (Check all that apply).
   - □ Manual Wheelchair
   - □ Power (electric) Wheelchair
   - □ Powered Scooter
   - □ Cane
   - □ Walker
   - □ White Cane
   - □ Service Animal
   - □ Crutches
   - □ Oxygen
   - □ Other (please list) _____

5. Which of the following weather/ environmental conditions if any, affect the applicant's disability or health condition such that it prevents him/her from independently getting to and/or from a bus stop?

Indicate: Heat □ Cold □ Humidity □ Snow □ Ice □ Pollution/Allergies □ Other □ N/A □

What specific weather condition prevents this person from getting around on his/her own? How so?

_____
_____
_____

6. Is applicant able to: ***Check all that apply***

- ☐ Understand and/or process information enabling them to use a Route Bus service
- ☐ Ask for or follow written or oral information, such as schedules including TDD, audio tape, or voice
- ☐ Figure out the correct fare?
- ☐ Follow instructions in an emergency?
- ☐ Recognize his/her destination while on a Route Bus?
- ☐ Once he/she gets off the bus at a Route Bus stop, locate and reach his/her destination?
- ☐ Cross a busy intersection to get to and/or from a Route Bus stop?
- ☐ Find his/her way between familiar locations?
- ☐ Signal the bus driver to get off a Route Bus at a familiar Route Bus stop and then get off the bus? (Assume the driver calls out all stops)
- ☐ Grasp coins, passes and handles?
- ☐ Communicate addresses, destinations, and telephone numbers on request in order to convey to a route driver their final desired destination?
- ☐ Deal with unexpected situations or unexpected changes in routine, e.g., route changed due to road construction, regular route bus stop closed?
- ☐ Go up and down steps unassisted?

7. Any additional information you believe pertinent to the applicant's situation.

_____
_____
_____

Name of Healthcare Professional:

Address:_____

City, State, Zip:_____

Phone number _____

Name and Title _____

**Signature of Healthcare Professional**: _____

**Note to Healthcare Professional:** Please return the Authorization and Healthcare Professional Verification forms to the applicant for submittal.