

Priority Paratransit Eligibility FAQ

What is Americans with Disabilities Act (ADA) Priority Paratransit? Smart Transit's (formerly Valley Transit) ADA Priority Paratransit program is for individuals who, due to a health condition or disability, are unable to use Smart Transit's lift-accessible fixed route bus system for some or all of their trips. (The fixed route system has buses that follow the same route several times a day and stop at designated locations at scheduled times. No appointment is necessary for the fixed route.)

What is the Americans with Disabilities Act (ADA)? The ADA is a civil rights bill that requires fixed route public transportation systems to provide comparable paratransit service to eligible individuals with disabilities. Comparable service includes: 1) origins and destinations within a corridor of $\frac{3}{4}$ mile on either side of each fixed route, along with any small area not inside any corridor but is surrounded by corridors; 2) providing paratransit service at any requested time (time is negotiable) on a particular day in response to a request for service made the previous day during normal business hours; 3) the fare cannot exceed twice the full fare for a comparable trip on the fixed route system; 4) and ADA paratransit service must be available during the same hours and days of service as the fixed route service (49 CFR §37.131).

Why must I apply for ADA Priority Paratransit? In order to provide the best service, Smart Transit must determine which of its clients are eligible for ADA Priority Paratransit. You must be determined eligible in order to take advantage of ADA Priority Paratransit services. Application does not guarantee eligibility.

How do I apply for ADA Priority Paratransit? You must apply by filling out the Smart Transit ADA Priority Paratransit application in full. Incomplete applications will be returned to you, causing delays in your application process. The process should not take longer than 21 days from the date of submission of your completed application. **If the determination cannot be made in 21 days from the date of submission, you will be presumed eligible until the determination is completed.** You may have another individual complete the application for you. If you are under the age of 18 or require a legal guardian, a parent or legal guardian must sign the application. It may be necessary for Smart Transit to seek additional information from you, by phone or in person, and to verify your disability with a licensed professional. The more detailed information you can provide, the better you enable Smart Transit to make the most appropriate determination regarding your transportation needs.

What will the eligibility determination mean to me? If you are determined fully eligible, you have the right to the level of service comparable to that which is provided to individuals without disabilities who use the fixed route system. If you are determined conditionally eligible, you have the same right under certain conditions (examples: for certain trips but not others or under certain weather conditions but not others). If you are determined temporarily eligible, you will have the same right for a specified time period. If you are denied eligibility, you cannot use Smart Transit's ADA Priority Paratransit service. Smart Transit will continue to provide our standard paratransit service, known as Dial-A-Ride, for those determined ineligible for ADA Priority Paratransit and for the general public on a space available basis.

How do I use Smart Transit's ADA Priority Paratransit? You call us during business hours of 8:00 AM to 5:00 PM, Monday through Friday, at (208) 883-7747 and make a reservation for your trip at least the day prior to your trip. Voicemail is available on Sundays and holidays until 5:00 PM to take reservation information for Monday and day-after-holiday trips. Please leave all the information you can, but especially your name and phone number where you can be reached on the evening prior and morning of your trip. Due to high demand for paratransit services and to accommodate all passengers with the best and most efficient service possible, you are encouraged to schedule your ride as soon as your need for

transportation arises. If you need to cancel your trip, please do so at least 15 minutes prior to your scheduled pick up time. If you cancel with less than 15 minutes until your scheduled pickup time, or do not cancel your trip, you will be considered a “no-show.” Too many “no-shows” could result in suspension of service.

What if I am denied eligibility or do not agree with the eligibility determination? You have the right to appeal the determination for 60 days following the receipt of the written notification of your eligibility status. Your appeal must be in writing.

What are the criteria for eligibility? ADA Priority Paratransit is for individuals whose health condition or disability *prevents* them from using the fixed route. Having a health condition or disability in and of itself does not guarantee eligibility. There are three categories of eligibility. The first category of eligible individuals are those with a disability who are unable, as the result of a physical or mental impairment, to independently board, ride, or exit vehicles which are readily accessible and usable by individuals with disabilities. The second category includes individuals with a disability who are able to board, ride, and exit accessible vehicles, but the particular route or destination required is not serviced by an accessible vehicle or bus stop. The third category includes individuals with a disability who are prevented from traveling to or from a bus stop due to their specific impairment-related condition or in combination with environmental and architectural barriers (49 CFR §37.123).

I’m on Medicaid or Social Security. Don’t I automatically qualify? Qualifying for Medicaid or Social Security benefits does not automatically qualify you for ADA Priority Paratransit service. ADA Priority Paratransit eligibility is based on functional ability to utilize the fixed route system as a result of a health condition or disability, not a medical assessment.

What factors are not considered for eligibility? The following issues are *not* considerations of eligibility for ADA Priority Paratransit: 1) Age, 2) Distance to a bus stop, 3) Lack of fixed route bus service to an area, 4) Weather conditions, and 5) Inability to speak English.

What if my condition changes? If your condition changes and you would like to be re-evaluated for ADA Priority Paratransit, you may fill out a new application for a new eligibility determination.

Will my information be kept private? Smart Transit keeps all client records confidential. The information used in determining your ADA Priority Paratransit Eligibility will only be used for that purpose. Only information relevant to your required trip needs will be given to those who perform those services. The ADA allows Smart Transit to share your eligibility status to transportation agencies in other areas should you require their services.

What if I have questions or need assistance filling out the application? If you have any questions, need assistance, or require a format that is more accessible to you, call Smart Transit at (208) 883-7747. If you need a TTY/relay operator, dial one of these toll-free numbers:

IF YOU LIVE IN IDAHO:

TTY/ASCII: 1-800-377-3529

Speech-to-Speech: 1-888-791-3004

Spanish-to-Spanish: 1-866-252-0684

IF YOU LIVE IN WASHINGTON:

TTY/Hearing Carry-Over: 1-800-833-6388

Voice Carry-Over: 1-800-833-6386

Speech-to-Speech: 1-877-833-6341

Telebraille: 1-800-833-6385

Smart Transit’s office hours are 8:00 AM to 5:00 PM, Monday through Friday.

SMART TRANSIT

Americans with Disabilities Act (ADA) Priority Paratransit Eligibility Application

If you have questions or need help, call 883-7747. For TTY/Relay service, call one of the toll free numbers below:

IF YOU LIVE IN IDAHO:

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If you require an alternative format, please indicate:

Audiotape

Large print

Data compact disc

Audio compact disc

Mail application to: Smart Transit
PO Box 3854
Moscow, ID 83843

Drop off only at:
1006 Railroad Street
Moscow

For office use only

Date Received: _____

IC: ____ Date Complete: _____

Please print or type. Complete all parts of the application. Incomplete applications will cause delays in your eligibility determination. The more detailed information you can provide, the better you enable Smart Transit to make the most appropriate determination regarding your transportation needs.

PART A Applicant Information

Name: _____
First Middle Initial Last

Street Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____

Mailing Address (if different): _____ Apt. # _____

City: _____ State: _____ Zip Code: _____

Day Telephone: _____ Evening Telephone: _____

E-Mail Address: _____

Birthdate: ____/____/____ Last four digits of SSN (optional): _____

Person completing application for the applicant (if applicable):

Name: _____ Legal guardian? Yes No

Day Telephone: _____ Evening Telephone: _____

Relationship to applicant: _____

Emergency Contact Person

Name: _____

Day Telephone: _____ Evening Telephone: _____

Relationship to applicant: _____

PART B Mobility/Functional Information

1. Which of the following mobility/communication aids do you use? (Check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Cane | <input type="checkbox"/> Brace | <input type="checkbox"/> Service Animal |
| <input type="checkbox"/> White Cane | <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Picture Board |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Powered Wheelchair | <input type="checkbox"/> Alphabet Board |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Powered Scooter/Cart | <input type="checkbox"/> Hearing Aid |
| <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Boarding Chair | <input type="checkbox"/> Portable Oxygen |
| <input type="checkbox"/> Other (please specify): _____ | | |
| <input type="checkbox"/> None | | |

If you use a wheelchair/scooter/cart:

Is it wider than 30 inches? Yes No

Is it longer than 48 inches? Yes No

Is the combined weight of you and your mobility device more than 600 pounds? Yes No

2. When traveling, does your health condition or disability require you to travel with another person for assistance, such as a personal care attendant (PCA)? Yes No

If you answered yes, please describe how the person assists you during travel (for example, "He/she must push my wheelchair" or "He/she keeps me from getting lost"): _____

3. How far can you walk or travel without the assistance of another person?

- None 1/2 block 1/4 mile 3/4 mile or more

A. Can you travel this distance in snow or ice?

- Yes No Sometimes (please explain): _____

B. Can you travel this distance on uneven or steep ground?

- Yes No Sometimes (please explain): _____

4. Can you climb and descend 12 inch steps without assistance if there are hand rails?

- Yes No If yes, how many in succession? _____

5. Please check the boxes that describe your mobility and functional skills (this does not refer to being unaccustomed to the English language or lack of familiarity with the service area).

I have the ability to:

- A. Understand how to take a trip on a fixed route bus Yes No Sometimes
- B. Read and understand a bus schedule Yes No Sometimes
- C. Tell time Yes No Sometimes
- D. Count bus fare or change Yes No Sometimes
- E. Recognize bus route names or numbers Yes No Sometimes
- F. Recognize landmarks like churches or street signs Yes No Sometimes
- G. Identify correct bus stop Yes No Sometimes
- H. Hold on to a hand rail Yes No Sometimes
- I. Maintain balance in a moving vehicle while in a sitting position Yes No Sometimes
- J. Transfer from a sitting to a standing position Yes No Sometimes
- K. Breathe without difficulty Yes No Sometimes
- L. Use a telephone to get information Yes No Sometimes
- M. Understand spoken words or auditory information Yes No Sometimes
- N. Communicate needs Yes No Sometimes
- O. Remember directions to a location Yes No Sometimes
- P. Deal with changes in routine (example: bus detours) Yes No Sometimes
- Q. Walk or wheel independently Yes No Sometimes
- R. Cross streets Yes No Sometimes

Please explain any “no” or “sometimes” answers:

PART C Health Condition/Disability Information

6. Smart Transit's fixed route system uses vehicles equipped with wheelchair lifts. Other features also make the system accessible to persons with disabilities such as the driver announcing bus stops and availability of materials in alternative formats.

What is the nature of your health condition and/or disability that prevents you from using the accessible fixed route bus system? Please check only those condition(s) or disability(ies) that affect your ability to board, ride, or exit the bus; understand how to use the fixed route system; get to or from the bus stop; or wait any length of time at a bus stop. (Check all that apply)

A. GENERAL MEDICAL

- | | | |
|-----------------------------------|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Failure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Organ Transplant |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Other (please specify): _____ | |

B. BONE AND JOINT

- | | | |
|--|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fusion | <input type="checkbox"/> Scleroderma |
| <input type="checkbox"/> Osteo-Arthritis | <input type="checkbox"/> Ankylosing Spondylitis | <input type="checkbox"/> Hip Disarticulation |
| <input type="checkbox"/> Amputation (please specify): _____ | | |
| <input type="checkbox"/> Broken Bone (please specify): _____ | | |
| <input type="checkbox"/> Other (please specify): _____ | | |

C. BRAIN/NERVES/MUSCLE

- | | | |
|--|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Guillian-Barre | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Hemiplegia | <input type="checkbox"/> Post-Polio |
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Huntington's Chorea | <input type="checkbox"/> Quadriplegia |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Frailty |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Paraplegia | <input type="checkbox"/> Vertigo/Dizziness |
| <input type="checkbox"/> Amyotrophic | <input type="checkbox"/> Friedreich's Ataxia | <input type="checkbox"/> Lateral Sclerosis |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Other (please specify): _____ | |

D. HEART AND CIRCULATORY

- | | | |
|--|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Edema |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Other (please specify): _____ | | |

E. RESPIRATORY

- None Asthma Emphysema
Allergies Cystic Fibrosis Lung Cancer
Chronic Obstructive Pulmonary Disease (COPD)
Other (please specify): _____

F. VISION/HEARING/SPEECH

- None Totally Blind Visual Field Deficit
Aphasia Diabetic Retinopathy Deaf-Blind
Cataracts Partially Sighted Deaf
Glaucoma Night Blindness Hard of Hearing
Other (please specify): _____

G. DEVELOPMENTAL/MENTAL

- None Psychosis Thought Disorder
Autism Dwarfism Mood Disorder
Mental Retardation Developmental Disability
 Mild Mild
 Moderate Moderate
 Severe Severe
Other (please specify): _____

7. Is your health condition or disability temporary?

- Yes No Some are temporary (if more than one)

How long do you expect the temporary health condition or disability to last? _____

8. Please describe your health condition or disability:

- Stable Changeable Deteriorating Improving

9. Is your health condition or disability adversely affected by:

- None Cold weather Hot weather Strong sunlight
Wind Air pollution Other: _____

10. Is your medication affected by extremely hot or cold weather?

- Yes No

PART D Fixed Route Information

11. How do you get to your destinations now? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Smart Transit fixed route buses | <input type="checkbox"/> Drive myself |
| <input type="checkbox"/> By myself | |
| <input type="checkbox"/> With help | |
| <input type="checkbox"/> Smart Transit paratransit (Dial-A-Ride) | <input type="checkbox"/> Someone drives me |
| <input type="checkbox"/> Another provider's paratransit | <input type="checkbox"/> Taxi |
| <input type="checkbox"/> Social Service Agency Vehicle | <input type="checkbox"/> Other: _____ |

12. Have you ever ridden Smart Transit fixed route buses?

- Yes No

If you answered no, why not? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Have been using Dial-A-Ride | <input type="checkbox"/> Did not know they were accessible |
| <input type="checkbox"/> Did not know they had wheelchair lifts | <input type="checkbox"/> Never thought about it |
| <input type="checkbox"/> Did not have information on routes | <input type="checkbox"/> Never wanted to |
| <input type="checkbox"/> Cannot board the bus by myself | <input type="checkbox"/> Don't know how |
| <input type="checkbox"/> Cannot recognize when it's my stop | <input type="checkbox"/> Don't understand the schedule |
| <input type="checkbox"/> Cannot get to the bus stop by myself | <input type="checkbox"/> It's confusing |
| <input type="checkbox"/> Bus stop is too far away | <input type="checkbox"/> Other: _____ |

13. The driver always operates the wheelchair lift. Either in your wheelchair or standing, can you get on and off a bus using the lift?

- Yes No Don't know Don't need the lift, I can use the regular door

14. Have you ever had any training or instruction on how to use the fixed route buses?

- Yes No

If you answered yes, please explain: _____

15. Presently, Smart Transit does not provide training to use the fixed route buses (however, we will answer your questions, please ask!), but in the future would you be interested in receiving such training?

- Yes No Maybe

16. Can you travel from your residence to the nearest bus stop without assistance from another person?

- Yes No Sometimes Don't know

If you answered sometimes or no, what barrier(s) prevent you from doing so? (Check all that apply)

- A. Cannot travel the terrain (hills, etc.) G. Extremely hot weather
 B. Unable to cross street(s) H. Extremely cold weather
 C. Get confused or lost I. Dark time of day (night blindness)
 D. Cannot walk/wheel that far J. Bright sunlight (light sensitive)
 E. The stop has no curb cut for my wheelchair/scooter/cart
 F. Other: _____

17. It is important that Smart Transit understands why your disability or health condition prevents you from using the fixed route system. Please state the reasons why you believe you are unable to board, ride, and exit the fixed route buses; understand how to use the fixed route system; get to or from the bus stop; or wait any length of time at a bus stop? Please list all reasons you can think of and be specific. (Use additional paper if necessary)

18. Please make additional comments or anything else you want known about your health condition/disability so that the most appropriate determination can be made:

PART E AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Instructions for Completing this Release

By signing below you are signing a release for Smart Transit (formerly Valley Transit) to ask your health practitioner(s) or other licensed professional to release any and all information verifying your health condition(s) and/or disability(ies) and information regarding your functional and cognitive abilities needed to utilize local public transportation. This information may assist in the determination of eligibility for paratransit services as defined in the Americans with Disabilities Act (ADA). Your signature will allow the practitioner(s) to supply this verification.

Authorization For Release of Medical Information

I am seeking eligibility for paratransit services as defined in the Americans with Disabilities Act (ADA). As part of the application process, I hereby authorize Smart Transit to obtain any and all information verifying my health condition(s) and/or disability(ies) and information regarding my functional and cognitive abilities needed to utilize local public transportation.

You, the licensed professional, are authorized to release information regarding my medical condition or disabilities, whether the information was initially prepared by you, or by some other person or entity, even if the person or entity that prepared the information is not associated with or employed by you. You are also authorized to release information generated after the date this authorization was signed.

In accordance with HIPAA, I understand that I have the right to revoke this authorization at any time by writing to Smart Transit. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. Further, I understand that this authorization is voluntary.

I understand the information disclosed pursuant to this release is for use by the Federal Transit Administration, its grantees, and Smart Transit for the provision of public transit services and that it may be disclosed by the Federal Transit Administration, its grantees and Smart Transit only as authorized by law, but will no longer be subject to the HIPAA privacy rule.

Photocopies of this authorization with my signature are valid. This authorization is valid for six (6) months from the date signed.

Name of Licensed Professional: _____

Complete Address: _____

Telephone: _____

(Types of licensed professionals you may list are: Physician, Nurse Practitioner, Physician's Assistant, Vocational Rehabilitation Counselor, Psychiatrist, Chiropractor, Mental Health Clinician, Psychologist, Physical Therapist, Occupational Therapist, Social Worker (MSW), Special Education Teacher, Respiratory Therapist, etc.)

SIGN HERE!

Applicant or Legal Guardian Signature: _____ **Date:** ____ / ____ / ____

If signature is the Legal Guardian's, check this box: Yes Day Telephone: _____

VERIFICATION OF LEGAL GUARDIANSHIP OR POWER OF ATTORNEY MUST BE INCLUDED.

PART F Applicant Signature

I hereby certify that the information given is true and correct to the best of my knowledge. I understand falsifying information may result in denial of service. **The information obtained in the evaluation will only be used by Smart Transit and Federal Transit Administration and its grantee for the provision of public transit services. The information will be kept confidential and will not be provided to any other persons or agencies except as authorized in this application.**

I understand that this application is an assessment of my ability to use the fixed route bus service and to determine if I am eligible for paratransit services as defined in the Americans with Disabilities Act (ADA). Eligibility may be classified as conditional or temporary. Additional information from me, by telephone or in a personal interview, or consultation with my physician or other professional may be required. Re-certification may be required periodically.

I understand the application process will take up to 21 days from the date Smart Transit receives this completed application and an incomplete application can cause additional delay. I understand that if a determination is not made in 21 days from receipt of a completed application, I will be presumed eligible until a determination is made. I understand that I may appeal within 60 days of the receipt of written notification of the determination.

SIGN HERE!

Applicant or Legal Guardian Signature: _____ **Date:** ____ / ____ / ____

If signature is the Legal Guardian's, check this box: Yes Day Telephone: _____

VERIFICATION OF LEGAL GUARDIANSHIP OR POWER OF ATTORNEY MUST BE INCLUDED.