



Dear Applicant:

Thank you for inquiring about Valley Regional Transit (VRT) Americans with Disabilities Act (ADA) Paratransit service, more commonly known as “Access” Service. Enclosed is the VRT Access Application Package required to initiate the ADA Paratransit application process. Please read this letter and the enclosed materials carefully before completing the included forms.

Individuals unable to use public transportation due to a disability or health-related condition may be eligible for Access Service. Eligibility for Access Service may include: not being able to get to or from bus stops; inability to get on or off buses; or an inability to understand how to ride or use the bus system due to a disability. Please complete the Access Application Package completely and accurately in order to initiate your application process and determine your eligibility. Information about your disability or medical condition will be kept confidential. After you have completed Sections I – VII A., please have a licensed healthcare professional complete Section VII B. “Professional Verification”. **The entire application package will be returned to you if any section is incomplete.**

The verification process will begin once a completed application has been received by VRT, which includes Section VIII, Application Review and Interview Scheduling. Close attention to the directions outlined in Section VIII will expedite your application review. The verification process will consist of a telephone interview, and in some cases, an in-person functional assessment conducted by a third-party professional selected by Valley Regional Transit. VRT will notify you of your eligibility status by mail within twenty-one (21) days of receiving a completed application.

Our goal is to provide safe, reliable and accessible transportation to our customers. We continue to improve our fixed route service (city bus) which offers many personalized options to aid individuals with disabilities. Valley Regional Transit’s entire bus fleet is equipped with wheelchair lifts and securement areas.

If you need assistance completing the form, have questions about Access Service and eligibility, or need additional accommodations, please feel free to call 208-345-RIDE (7433) or the Idaho Relay Service at (800) 377-1363. The details for returning a completed application can be found in Section VIII of this application package.

Sincerely,

Valley Regional Transit

I. REQUIRED INFORMATION

Please print legibly

Name (first, middle, last): _____

Female Male

Home address: _____ Apt #: _____

City/State: _____ Zip: _____

Mailing address: _____ Apt #: _____

City/State: _____ Zip: _____

Telephone: (____) _____ Birth Date: ____/____/____

II. PRESENT MEANS OF TRAVEL

1. Do you currently use Public Transportation (City Bus)? Yes No

2. Have you ever ridden on a ValleyRide City Bus? Yes No

A. If yes, when was the last time you rode a ValleyRide City Bus (select one)?

- Last 3 months Last 6 months Last 12 months Last 2 years
 Last 5 years More than 5 years I've never ridden a ValleyRide bus

B. If yes, in the last 2 years or less, which routes? I rode, but am unsure of the route

- #51- Nampa South #52 – Caldwell South #53 – Nampa Garrity
 #54 – Caldwell North Boise Buses Intercounty Routes
 #42 Nampa/Meridian Limited Stop

3. Have you ridden other public transportation (city bus) regularly in another city? Yes No

A. If yes, when was the last time you rode a city bus?

- Last 3 months Last 6 months Last 12 months Last 2 years
 Last 5 years More than 5 years I've never ridden a city bus

4. Which ValleyRide Bus Route (or major intersection) is closest to your home?

PRESENT MEANS OF TRAVEL CONTINUED ...

5. Have you ever received travel training on how to use public transportation (city bus) service?

- Yes No

6. Are you aware that persons with disabilities can ride the ValleyRide City Bus for half-fare?

- Yes No

The disabled bus fares are as follows: One Ride: 50 cents All Day Pass:\$1 Monthly Pass:\$18

7. How do you currently travel to your most frequent destinations? (Check all that apply)

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Buses | <input type="checkbox"/> Paratransit | <input type="checkbox"/> Friend/Relative drives vehicle |
| <input type="checkbox"/> Walk | <input type="checkbox"/> School Bus | <input type="checkbox"/> Private Taxi, Car or Van |
| <input type="checkbox"/> Drive myself | <input type="checkbox"/> Other, Please Explain: _____ | |

III. ANALYSIS OF APPLICANT NEEDS AND ABILITIES

8. Please identify the type of disability or health-related condition(s):

- Visual Is this condition? Permanent Temporary Don't Know
- Cognitive Is this condition? Permanent Temporary Don't Know
- Mobility Is this condition? Permanent Temporary Don't Know

9. What disability or health-related condition prevents you from using public transportation or the city bus (i.e.; Cerebral Palsy, Traumatic Brain Injury, Arthritis, Glaucoma, and etc.)?

10. What are the specific conditions about your disability or health-related condition that prevents you from using ValleyRide Bus Services? (Check all that apply)

- If bus stops were closer to where I live and need to go.
- I can use the city bus service sometimes, but for certain trips either I have been not been trained or there are other barriers present.
- I have difficulty navigating the bus system.
- I cannot understand and remember directions.
- I am unable to get to the bus stop or from the bus stop to my final destination due to environmental barriers such as no sidewalk, impossible street crossings, etc.
- Weather elements affect my disability.
- Don't Know.
- Other, please explain: _____

ANALYSIS OF APPLICANT NEEDS AND ABILITIES CONTINUED ...

11. Do you use any mobility aids or specialized equipment?

- Cane Power Chair Manual Chair Large Power Chair
- White Cane Service Animal Walker Power Scooter (3 or 4 wheeler)
- Crutches Leg Braces Speech Devices Communication Board
- Respirator Prosthesis Portable Oxygen Tank Other _____

Personal Care Attendant (defined as someone designated or employed specifically to help the eligible individual meet his or her personal needs). A person traveling to keep the passenger company is considered a guest and not a Personal Care Attendant.

IV. APPLICANT SIGNATURE

I certify that the information I gave in the application is true and correct. I understand that falsification of information may result in denial of service. I understand all information will be kept confidential; only the information required to provide services I request will be disclosed to those who perform those services. The application will not be processed without applicant's signature.

Applicant Signature Date: _____

Applicant Name (Please print)

V. OPTIONAL, IF PERSON OTHER THAN APPLICANT IS COMPLETING FORM

Please check one of the items below:

- I certify that the information provided in this application is true and correct based upon information given to me by the applicant.
- I certify that the information provided in this application is true and correct, based upon my own knowledge of the applicant's health condition or disability.

Signature _____ Date: _____

Print Name _____ Daytime Phone number: _____

Address: _____

Relationship to Applicant: _____

VI. AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(to be completed by applicant)

I hereby authorize the following licensed professional (doctor, therapist, social worker, etc.), who can verify my disability or health-related condition, to release this information to Valley Regional Transit eligibility certification staff or a contractor working for the agency to conduct eligibility screenings. This information will be used only to verify my eligibility for ADA paratransit services. I understand that I have the right to request and receive a copy of this authorization, and that I may revoke it at any time.

Name of Medical Professional who may release my medical information:

Name of Medical Professional

Address of Medical Professional

City, State and Zip Code

Telephone Number of Medical Professional

Facsimile Number of Medical Professional

Medical Record or Identification Number, if known

Applicant Name (Please Print) _____

Applicant Signature: _____ Date: _____

VII. PROFESSIONAL VERIFICATION

Section A: To Be Completed by Applicant/Patient

Applicant/Patient Name (first, middle, last): _____
Home address: _____ Apt #: _____
City/State: _____ Zip: _____
Mailing address: _____ Apt #: _____
City/State: _____ Zip: _____
Telephone: (____) _____ Birth Date: ____/____/____

Section B: To Be Completed by Certifying Professional ONLY

This section must be completed and signed by one of the following currently licensed professionals. The professional you identify below must have direct knowledge of your disability and the impact of your disability on how it prevents you from using fixed route public transportation. The applicant is not to complete any of the information below.

The Americans with Disabilities Act of 1990 (ADA) is a civil rights law which bans discrimination against people with disabilities. To meet their needs, public transportation companies must provide a variety of services. The applicant may be found eligible for paratransit services for all trips he or she requests or eligible (based on functional ability) for some trip requests but not for others, or ineligible because he or she is capable of using the city bus system. The information you provide will enable us to make an appropriate determination for this applicant. All information will be kept confidential. Thank you for your assistance.

- | | |
|--|--|
| <input type="checkbox"/> Vocational Rehabilitation Counselor | <input type="checkbox"/> Special Education Teacher |
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Speech Pathologist |
| <input type="checkbox"/> Social Worker | <input type="checkbox"/> Physician |
| <input type="checkbox"/> Respiratory Therapist | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Registered Nurse | <input type="checkbox"/> Occupational Therapist |
| <input type="checkbox"/> Recreation Therapist employed by Medical Facility | <input type="checkbox"/> Nurse Practitioner |
| <input type="checkbox"/> Qualified Mobility/Independent Living Specialist | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Certified Orientation/ other Blindness Professional | <input type="checkbox"/> Physician's Assistant |

Please identify any and all medical diagnosis, physical or cognitive condition, which prevents the applicant from riding fixed route (city bus) service:

Is this condition temporary: Yes, ____ months No

Exceptions or additions: _____

PROFESSIONAL VERIFICATION CONTINUED ...

The applicant has applied for transportation services for persons with disabilities. Please answer the following information regarding his/her eligibility for transportation services:

1. What **DISABILITY** or **HEALTH-RELATED CONDITION** prevents the patient from using public buses?

Mobility Impairment _____ Visual Impairment _____ Cognitive Impairment _____

Diagnosis: _____

2. Is the patient's condition **Permanent** or **Temporary** (please circle one)? If temporary, how long will the patient need our handicap/disabled transportation services? _____ months

3. How many city blocks can the patient travel (with the primary mobility aid) without the help of another person?

None ____ 3 City Blocks ____ 6 City Blocks ____ 9 City Bocks ____
1 City Block or less ____ 4 City Blocks ____ 7 City Blocks ____ 10 City Blocks ____
1 to 2 City Blocks ____ 5 City Blocks ____ 8 City Blocks ____ Unlimited ____

4. Is the patient able to stand and sit for 15 minutes? Yes ____ No ____

5. Is the patient able to travel under the following conditions:

Cross Intersections? Yes ____ No ____ Areas without sidewalks? Yes ____ No ____
Able to use a few stairs? Yes ____ No ____ Snow or Icy conditions? Yes ____ No ____
Bus Transfers Yes ____ No ____ Temperature Sensitivity** Yes ____ No ____
Comprehend directions? Yes ____ No ____ Poor Air Quality** Yes ____ No ____
Uneven Ground Yes ____ No ____ **List temperature(s) and/or Air Quality rating
restrictions _____

I certify that the information contained in this application is true and correct to the best of my knowledge and ability.

Print Name _____ License # _____

Signature _____ Date: _____

Daytime Phone number: _____ Agency/Clinic: _____

Address: _____ Apt #: _____

City/State: _____ Zip: _____

VIII. APPLICATION REVIEW AND INTERVIEW SCHEDULING

Before beginning the final steps of your application submission, please review to ensure the following items are completed. Your efforts to verify and ensure the information is accurate and complete will expedite the application process. Please verify the following:

- Section I: Name (including spelling) and all contact information is accurate and complete.
- Section II: All questions are answered and responses are accurate.
- Section III: Complete and accurate description of disability, including precise medical/physical descriptions and applicable mobility devices.
- Section IV: Verify the applicant name is printed, signed and dated.
- Section V: If completed by someone other than the applicant, ensure this section is completed in full.
- Section VI: Complete the Authorization to Release Medical Information form with accurate contact information for the professional relevant to your disability. Requires the applicant name to printed, signed and dated.
- Section VII:
 1. Section A: Complete ONLY the top section, providing accurate and complete contact information.
 2. Section B: Verify this information has been completed by the professional verifying your disability and mobility limitations. The applicant MAY NOT complete any items under Section B.
- Section VIII: Verify the information described above is complete and then proceed to the steps below.

Now that you have reviewed the steps above and confirmed your application is complete, please perform the following two processes:

- Please contact Valley Regional Transit, 208/345-7433 to schedule your telephone interview. All applicants or representatives are required to participate in a telephone interview. Call the above telephone number and you will be provided an interview confirmation number. If there is no confirmation number written below, the application will be returned as incomplete.

My interview confirmation number is: _____

- Mail your application to the address below immediately. It is critical that your application be immediately mailed, as without receipt of your application package, your interview will be rescheduled and therefore delay your completed application and subsequent review.

Immediately return this completed application to:

Valley Regional Transit
Attention: Access Services
700 N. East 2nd Street, Suite 100
Meridian, Idaho 83642

Thank you.

Valley Regional Transit