Certification of ADA Paratransit Eligibility

The information obtained in this certification process will be used by the North Central Regional Transit District (NCRTD) for the provision of transportation services. Information will only be shared with other transit providers to facilitate travel in those areas. The information will not be provided to any other person/agency.

☐ First Time Applicant  ☐ 3 Year Renewal Applicant  ☐ Physical Address Change

1. Name _________________________________________________________________

2. Physical Address ______________ City State Zip ______________

   Mailing Address ______________ City State Zip ______________

3. Telephone Number (Home) ______________ (Cell) ______________ (Work) ______________

4. Date of Birth ______ / ______ / ______

5. Which of the following best describes your disability?

   _____a. The condition I have prevents me from using the fixed route system (NCRTD Bus Service) permanently.

   _____b. My condition is temporary, and I should be able to use the fixed route system (NCRTD Bus Service) by ________ (date).

   _____c. My condition is intermittent ________% of the time and I will not be able to use the fixed route system (NCRTD Bus Service)

6. How does this disability prevent you from using NCRTD fixed route service? Please explain completely. Use additional sheet if needed.

   ___________________________________________________________________

   ___________________________________________________________________

7. Are there any other effects of your disability of which we need to be aware of?

   ___________________________________________________________________

   ___________________________________________________________________

The following information will be used to ensure that an appropriate vehicle is utilized to provide your transportation and that an accurate analysis of your trip requests can be made by NCRTD
8. Do you use any of the following aids for mobility? (check all that apply)

   ______ Manual Wheelchair    ______ Cane    ______ Service Animal
   ______ Powered Scooter    ______ Walker    ______ Personal Care Attendant
   ______ Electric Wheelchair    ______ Crutches

9. Do you need the assistance of a Personal Care Attendant when you travel using public transit?

   ______ Yes    ______ No

10. Please answer all of the following questions:

    Can you travel one city block without the assistance of another person?
        ______ Yes    ______ No    ______ Sometimes

    Can you travel 5 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 support for ten minutes?
        ______ Yes    ______ No    ______ Sometimes

11. Have you ever used NCRTD fixed-route buses?

   ______ Yes, I typically use NCRTD fixed-route buses ______ times a week
   ______ Yes, I used NCRID fixed-route buses but stopped because __________________________

   ______ No, I never use NCRTD fixed-route buses because __________________________

   ______________________________________________________________

   ______________________________________________________________

NOTE: Travel Training is personalized (individual or group) instruction that teaches the skills necessary to use NCRTD fixed-route bus service.

1. Have you ever had any personal instruction on how to use NCRTD fixed-route bus service?

   ______ No, I have never received any Travel Training
   ______ Yes, I have received personal Travel Training instruction through an NCRTD employee:

   Name of NCRTD employee: ________________________________________________

   If you selected YES, please indicate below the skills you learned:

   ______ To travel to and from bus stops
   ______ To cross streets
   ______ To read bus schedules and plan trips
   ______ To ride the following routes:
   Route # ________ Route # ________ Route # ________ Route # ________
   ______ Other (please explain), _____________________________________________

2. Did you complete the above training?

   ______ Yes
   ______ No
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12. I hereby certify that the information given above is correct.

Signed_________________________  Date_______/_____/_____

13. Name of Emergency Contact_____________________________________

   Phone Number_________________________________________________

14. If this application has been completed by someone other than the person requesting certification, that person must complete the following:

   Name________________________________________________________

   Address____________________________________________________________________

   City_____________State___________Zip______________Phone____________________

   Signed_________________________________________  Date_______/_____/_____

RETURN FORM TO:
North Central Regional Transit District
Attention: Operations Department/Paratransit Application
1327 N. Riverside Drive
Española, NM 87532
RELEASE OF INFORMATION

In order to allow the NCRTD to evaluate your request, it may be necessary to contact the physician or other licensed professional, to confirm the information they will provide when you submit the following the “Requested for Professional Verification”. Please send complete applications only, incomplete applications will not be processed.

The person completing the “Request for Professional Verification” form is: (check one)

_________ Physician  ____________ Health Care Professional

_________ Rehabilitation Professional

This person is familiar with the effects of my disability and is authorized to complete the professional verification for the NCRTD required to complete this certification process.

Name

(Physicians or Professionals Name)

Address

(Physicians or Professionals Address)

City State Zip

Daytime phone Fax Number

Signed

(Date / / )

(Applicant Name)
REQUEST FOR PROFESSIONAL VERIFICATION

THIS SECTION TO BE COMPLETED BY PHYSICIAN, NURSE OR STATE LICENSED SOCIAL WORKER. ANY ALTERATIONS, DELETIONS OR ADDITIONS BY APPLICANT SHALL MAKE THIS APPLICATION VOID.

Note: Questions #3 and #6 must be completed to process the application.

Dear ______________________,

(Physician's Name)

The attached authorization form has been submitted by ______________________ (Applicant's Name).

He/She has indicated that you can provide information regarding his/her disability and its impact upon his/her ability to utilize our fixed route transit service North Central Regional Transit District (NCRTD Bus Service). Federal law requires that the NCRTD provide paratransit services to persons who cannot utilize available fixed route bus service (NCRTD Bus Service). The information you provide will allow us to make an appropriate evaluation of this request and its application to specific trip requests. Thank you for your cooperation in this matter. If you have any questions call (866) 206-0754.

1. Capacity in which you know the applicant:
   I am his/her _______________________.
   (patient's name)

2. Which of the following best describes your client's (patient's) disability?

   _____ a. The condition is permanent
   _____ b. The condition is temporary, and he/she should be able to use the fixed route service by ________________ (date).
   _____ c. The condition is intermittent ____________% of the time and he/she will not be able to use the fixed route service.

If you selected c. please explain your answer.

________________________________________________________________________
3. If the person has a disability affecting mobility, is the person:
   Able to walk one city block without the assistance of another person?
      _____ Yes       _____ No       _____ Sometimes
   Able to travel 5 city blocks without the assistance of another person?
      _____ Yes       _____ No       _____ Sometimes
   Able to climb three 12-inch steps without assistance?
      _____ Yes       _____ No       _____ Sometimes
   Able to wait outside without support for ten minutes?
      _____ Yes       _____ No       _____ Sometimes

4. Does this person use any mobility aids? Please select all that apply
      _____ Manual Wheelchair     _____ Cane       _____ Service Animal
      _____ Powered Scooter       _____ Walker      _____ Personal Care Attendant
      _____ Electric Wheelchair   _____ Crutches

5. Does this person require a personal care attendant when traveling using public transportation?
      _____ Yes       _____ No       _____ Sometimes

6. If the person has a visual Impairment:
   Visual Acuity with Best Correction:
      Right eye _______ Left eye _______ Both Eyes _______
   Visual fields:
      Right eye _______ Left eye _______ Both Eyes _______
   Can the person read 12 in font print? _______yes     _______no

7. If the person has a cognitive disability: Is
   the person able to:
   Give addresses and telephone number on request?
      _________ No       _______Yes
   Recognize a destination or landmark?
      _________ No       _______Yes
   Deal with unexpected situations or unexpected change in routine?
      _________ No       _______Yes
   Ask for, understand, and follow directions?
      _________ No       _______Yes
Safely and effectively travel through crowded and/or complex facilities?

_______ No  ______ Yes

8. Please describe below in detail what the disability of your patient is and what prevents them from using the NCRTD fixed route service. Please indicate if the applicant has a physical or a mental disability, and is there any other effect of the disability of which the NCRTD should be aware?

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Physician Name (Print):__________________________________________________________

Office Address:______________________________________________________________

Office Phone Number:___________________________________________________________

Physician/Healthcare Professional Signature:_________________________Date_______

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