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

Certification of ADA Paratransit Eligibility

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 routte 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 you 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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