CITY OF IOWA CITY

410 E. Washington Street, Iowa City, IA 52240
(319) 356-5151

ADA PARATRANSIT ELIGIBILITY APPLICATION AND INSTRUCTIONS

Dear Customer:

Thank you for inquiring about eligibility for "ADA Paratransit" service. Enclosed is a copy of an ADA Paratransit Application Form. **Please read this and the enclosed material carefully before completing the application.**

The Americans with Disabilities Act of 1990 (ADA) requires Iowa City Transit to provide equivalent public transportation to individuals with disabilities that cannot board, ride or get to an accessible fixed-route bus due to their disability. This service must be comparable to the service that is provided to individuals without disabilities. The law is very specific as to whom and under what circumstances eligibility may be granted to use Paratransit transportation. Paratransit eligibility is not automatically assumed because of a disability.

You or your designee must completely answer all questions. A detailed explanation of how your disability makes it functionally impossible for you to use an accessible bus is required and you must certify that information is complete and correct by signing and dating. You will also find a Medical/Professional Verification form to be completed by your physician or medical agency. ***Please complete your application as thoroughly as possible.*** The questions will assist us in determining the specific limitation you have in using our service.

It will be necessary for a licensed medical professional (not a relative or friend) that sees you on a professional basis to complete the medical verification portion of your application. This person may be a registered nurse, social worker, physician, physical therapist, psychologist, occupational therapist, chiropractor, speech pathologist, physician's assistant, nurse practitioner, or mental health counselor employed by a medical facility. ***Contact our office if assistance is needed in completing your application.***

BOTH THE CLIENT AND MEDICAL PROFESSIONAL VERIFICATION FORM MUST BE COMPLETED AND SUBMITTED TOGETHER. IF ANY SECTIONS ARE LEFT BLANK THE APPLICATION WILL BE RETURNED TO YOU AS INCOMPLETE AND IT WILL DELAY THE CERTIFICATION PROCESS.

The information you provide in this application is confidential.

All applicants, whether new or persons applying for recertification, must complete a new application. The ADA certification process may involve an in-person interview and/or functional assessment to determine your abilities to use Iowa City Transit's fixed-route service.

Applications should be returned to: Iowa City Transit
335 Iowa Avenue
Iowa City, IA 52240

If you are determined eligible for Iowa City's ADA Paratransit service, your eligibility will be for one of the following types:

1. **CONDITIONAL ELIGIBILITY:**
   You are able to use the fixed route buses for **SOME** of your trips, and qualify for ADA Paratransit Service for other trips.

2. **UNCONDITIONAL ELIGIBILITY:**
   Your disability or health condition always prevents you from using the fixed route buses and you qualify for ADA Paratransit for **ALL** of your trips.

3. **TEMPORARY ELIGIBILITY:**
   You have a health condition or disability that **TEMPORARILY** prevents you from using the fixed route buses and you qualify for ADA Paratransit for a specified period of time.

A determination is made based upon an individual's ability to board, ride and disembark independently from a fully accessible fixed-route vehicle. The terrain and architectural structure are also considered. It is important for all applicants to realize that this is a transportation decision, not a medical authorization.

Lack of Iowa City Transit fixed-route service in an area or at specific schedule times does not qualify as adequate justification for ADA Paratransit eligibility. Iowa City's ADA Paratransit service provides service within the incorporated city limits, three-quarters of a mile outside of Iowa City Transit's bus routes during the same hours as fixed-route bus service for those determined eligible.

A determination of eligibility will be made by Iowa City Transit within 21 days of receipt of the completed application. Iowa City Transit will notify you in writing of the decision about your eligibility for ADA paratransit service. If it is determined that you are able to use the fixed route system and are not eligible for paratransit service, Iowa City Transit will explain the reason for this determination. If you are determined **Not Eligible** for Iowa City's ADA Paratransit service, and/or are dissatisfied with your eligibility type you may appeal the decision. A written appeal to the **MPOJC (Metropolitan Planning Organization of Johnson County)** must be received within 60 calendar days of the denial letter. Simply submit a letter stating you wish to appeal the decision that was made and why you feel you should be eligible for ADA Paratransit service. Attach copies of any other pertinent information. The appeal decision by MPOJC is the final determination. You may only re-submit an application if your condition worsens. ADA Paratransit service will not be provided during the appeal process, unless the appeal process cannot be concluded within 30 days.

Appeals must be in writing and forwarded to:

MPOJC
Attn: ADA Paratransit Appeal
410 E. Washington
Iowa City, IA 52240

ADA PARATRANSIT PARTICIPATION AND RELEASE OF LIABILITY AGREEMENT (for Parents or Legal Guardians ONLY)

1. Applicant's Name:_____

2. I declare that the applicant is capable of riding Iowa City's ADA Paratransit service without being a danger to himself/herself, other passengers or because of his/her youth.

3. I agree that a personal care attendant to accompany the applicant is necessary if the client is not alert enough to be aware of surroundings due to physical and/or mental handicap.

4. If the applicant requires a personal care attendant, the care-provider/legal guardian must provide a responsible adult to accompany the applicant to and from the destination. The attendant will not be charged for the trip.

5. I agree to inform Iowa City Transit about any changes in equipment prior to scheduling of rides. If the applicant changes to equipment which provides less assistance (example: from wheelchair to walker) a doctor's certificate is to be given to Iowa City Transit including the appropriateness, or reason, the new equipment is to be used.

6. I agree to inform Iowa City Transit about any change that makes the applicant ineligible for Iowa City Transit's ADA Para-transit services.

7. Release of Liability: It is understood by the undersigned applicant/applicant representative that Iowa City Transit, its officers, employees and their successors, insurers and assignees are released from liabilities and shall be held harmless from any and all law suits, claims, losses, liabilities or damages due to personal injuries or property damage to a client caused by his/her mental or physical disability, to and from his/her door to the vehicle, and to and from his/her destination.

8. The undersigned agrees to and will follow all of the conditions of this agreement.

Signed: _____ Date: _____

Printed Name of Applicant: _____

Signature of Parent or Legal Guardian: _____ Date: _____

Printed Name of Parent or Legal Guardian: _____

Relationship to Applicant_____ Phone:_____

APPLICATION FOR ADA PARATRANSIT SERVICES

It is important to complete all parts of the attached form. Applications that are not fully completed or clearly written will be returned, which will delay the eligibility process. Please print.

Name:_____
First Middle Last

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Physical address (if different from mailing):_____

City:_____ State:_____ Zip Code:_____

Daytime Phone: (_____) _____ TDD/TYY: (_____) _____

Evening Phone: (_____)_____

Birth Date: _____/_____/_____
MM DD YY

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

Name_____

Address: _____

Relationship: _____ Phone: (_____) _____

Please indicate if this person should be contacted directly if additional information is requested.
Yes_____ No_____

Emergency Contact Person(s):

Name: _____ Day Phone: (_____) _____
(Primary Contact)
Relationship: _____ Evening Phone: (_____) _____

Name: _____ Day Phone: (_____) _____
(Secondary Contact)
Relationship: _____ Evening Phone: (_____) _____

About Your Disability

1. What type or types of disabilities prevent you from using standard bus service (check all that apply)

[ ] physical disability
[ ] developmental disability
[ ] other_____
[ ] visual impairment
[ ] mental illness
[ ] none

2. Is your disability: [ ] Permanent or [ ] Temporary
If temporary; what is the expected duration:
[ ] 0- 3 months [ ] 3 – 6 months [ ] 6 – 12 months [ ] 12 – 24 months [ ] Over 24 months

3. Which of the following mobility aides do you use while travelling? (Please check all that apply)

[ ] cane
[ ] long white cane
[ ] portable oxygen
[ ] walker
[ ] crutches
[ ] extra-large wheelchair
[ ] power wheelchair
[ ] manual wheelchair
[ ] power scooter/cart
[ ] service animal
[ ] prosthesis
[ ] communication board
[ ] other_____
[ ] none

4. Do you use a manual or power wheelchair or scooter? [ ] Yes [ ] No

Width(inches)	**Length(inches)**	**Weight(passenger + mobility device)**
[ ] 20 - 24	[ ]<42	[ ]<300 lbs
[ ] 25 - 28	[ ]42 - 48	[ ]300 – 400 lbs
[ ] 29 - 32	[ ]49 – 54	[ ]400 – 500 lbs
	[ ]>54	[ ] >500 lbs

	Yes	**No**	**Sometimes**
5. Are you able to wait 15 minutes at a public stop with your mobility device?	[ ]	[ ]	[ ]
6. Can you transfer from your wheelchair to a seat in a vehicle?	[ ]	[ ]	[ ]
7. Are you sensitive to heat?	[ ]	[ ]	[ ]
8. Are you sensitive to cold?	[ ]	[ ]	[ ]
9. Do other weather/lighting conditions affect your disability?	[ ]	[ ]	[ ]
10. Is your breathing affected by weather or environmental conditions?	[ ]	[ ]	[ ]
11. Does your disability change after medical treatment/medications?	[ ]	[ ]	[ ]

12. If you answered **No** or **Sometimes** to questions 5 – 11, please explain below:

1. Under the best of conditions what is the farthest you can walk (or travel using your mobility aid) without the help of another person?

[ ] Less than 1 block
[ ] 1 block
[ ] 2 blocks (1/4 mile)
[ ] 4 blocks (1/2 mile)
[ ] 6 blocks
[ ] More than 6 blocks
[ ] I cannot travel outdoors alone

		Yes	No	Sometimes
2.	Are you able to recognize printed information?	[ ]	[ ]	[ ]
3.	Are you able to cross streets by yourself?	[ ]	[ ]	[ ]
4.	Are you able to travel or get around by yourself after dark?	[ ]	[ ]	[ ]
5.	Are you able to travel by yourself along sidewalks and other pedestrian ways?	[ ]	[ ]	[ ]
6.	Are you capable and comfortable getting around in a store or shopping mall by yourself?	[ ]	[ ]	[ ]
7.	Are you able to detect curbs and other drop offs?	[ ]	[ ]	[ ]
8.	Are you able to travel to and from your neighborhood bus stop independently?	[ ]	[ ]	[ ]
9.	Are you able to wait outside without assistance or support for fifteen (15) minutes?	[ ]	[ ]	[ ]
10.	Are there barriers that prevent you from getting to and from the bus stop?	[ ]	[ ]	[ ]
11.	Are you able to leave and return to your regular destinations (local bus stops) independently?	[ ]	[ ]	[ ]
12.	Are you able to travel on flat surfaces in good weather?	[ ]	[ ]	[ ]
13.	Are you able to travel on slight inclines in good weather?	[ ]	[ ]	[ ]

	Yes	No	Sometimes
14. Could you wait if there were a seat or bus shelter?	[ ]	[ ]	[ ]
15. Could you wait if there was not a seat or bus shelter?	[ ]	[ ]	[ ]
16. Could you pay the fare by putting coins or tickets in the fare box, or by showing a pass to the bus driver?	[ ]	[ ]	[ ]
17. Are you able to independently call and make or cancel trip reservations?	[ ]	[ ]	[ ]
18. Can you wait alone at your residence and places to which you travel?	[ ]	[ ]	[ ]
19. Could you independently ride in a taxi if one were provided?	[ ]	[ ]	[ ]
20. Can you provide addresses and telephone numbers upon request?	[ ]	[ ]	[ ]
21. Are you able to ask for, understand and follow directions?	[ ]	[ ]	[ ]
22. Are you able to adapt to unexpected changes in routine?	[ ]	[ ]	[ ]

23. If you answered **No** or **Sometimes** to questions 2 – 22, please explain:

_____

_____

_____

_____

24. Do you require the services of a Personal Care Attendant (PCA) when you travel? (This person is not a companion or escort, but someone who will be helping you with mobility assistance, personal care, communication, transportation, sign language interpretation, providing services as a reader, etc., as you make your trip). [ ] Yes [ ] No

Please give Personal Care Attendant name: _____

(In order for your Personal Care Attendant to ride with you at no charge, you must inform the reservation/dispatch office staff that you will be accompanied by a Personal Care Attendant when making your ride request. The Personal Care Attendant is then responsible for assisting you, not the ADA Paratransit Driver.)

Boarding and Exiting the Bus

		Yes	No	Sometimes
1.	Do you now use regular fixed route bus service?	[ ]	[ ]	[ ]
2.	Are you able to recognize changes in your mental/emotional state that prevent you from using regular route service?	[ ]	[ ]	[ ]
3.	Do you have to go up and down steps in your home or residence?	[ ]	[ ]	[ ]
4.	Can you safely and independently walk up and down three (3) 12 inch steps?	[ ]	[ ]	[ ]
5.	Are you able to board, ride, or exit a wheelchair accessible bus without assistance?	[ ]	[ ]	[ ]
6.	Are you able to grasp handles or a railing while boarding or exiting a bus?	[ ]	[ ]	[ ]
7.	Are you able to board or exit a vehicle if it has a lift or kneeler that lowers the front of the bus?	[ ]	[ ]	[ ]
8.	Are you able to get on and off a bus without assistance?	[ ]	[ ]	[ ]

9. If you answered **No** or **Sometimes** to questions 1 - 8, please explain:

_____

_____

_____

_____

10. Have you ever had training to learn how to travel around the community or how to use the fixed-route buses? [ ] Yes [ ] No

11. Is there something that might help you to ride the regular fixed route bus system? (Please check all that apply):

- [ ] Yes, if someone taught me to understand the route, schedule and fare information
- [ ] Yes, if someone were to show me how to ride the bus
- [ ] Yes, if someone showed me how to get on the bus using the lift
- [ ] Yes, if the bus were to come closer to where I live and need to go
- [ ] No, none of these would help

Release of Information

I, the applicant, understand that the purpose of this application is to determine my eligibility to use Iowa City Transit's paratransit service. I hereby authorize my health care professional to release information about my disability and its effect on my ability to travel, which may be needed in connection with my request for ADA paratransit eligibility certification.

I agree to notify Iowa City Transit of any changes in status of my disability that affects my ability to use paratransit service. I hereby certify that the information in this application is true and correct. I understand that falsification of the information may result in denial of service. I understand all information will be kept confidential and only the information required providing the service I request will be disclosed.

I hereby certify that I am the individual requesting certification for ADA paratransit service and that all information contained in this application is true and accurate:

Signed:_____ Date:_____

Printed Name of Applicant:_____

If the applicant is a minor or has a legal guardian the parent or guardian must sign this Application, and attest to the accuracy of the information contained herein.

Signature of Parent or Legal Guardian:

_____ Date:_____

Relationship to Applicant_____ Phone:_____

The next part of the application must be filled out by a health care or human services professional who is familiar with the applicant's disabling condition and/or functional limitation.

In the space provided below, CLEARLY PRINT the name of the Professional who will be verifying your application, and specify his/her position.

Name of professional _____

Professional affiliation:

[ ] licensed physician
[ ] licensed occupational therapist
[ ] nurse (LPN or RN)
[ ] certified rehabilitation
[ ] vision specialist
[ ] Psychiatrist, psychologist or mental health counselor
[ ] licensed physical therapist
[ ] licensed social worker
[ ] certified psychologist
[ ] speech pathologist
[ ] orientation/mobility specialist
[ ] audiologist/hearing specialist
[ ] ophthalmologist

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Physician's Verification of Disability

THIS PORTION OF THE FORM MUST BE COMPLETED AND SIGNED BY AN APPROPRIATE MEDICAL, CERTIFIED OR LICENSED PROFESSIONAL WHO IS TREATING THE APPLICANT

Dear Health Care Professional:

The Americans with Disabilities Act of 1990 (ADA) requires public transit agencies to provide paratransit service to people whose disabilities prevent them from using a bus some or all of the time. Disability alone and distance to and from a bus stop **DO NOT**, by themselves, qualify a person for ADA Para-transit service. Inconvenience and/or decreased comfort **ARE NOT** a basis for qualification. The client's condition must **PREVENT** travel by bus. 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.*

Client Name _____

Please do not list "diagnosis" as the reason the applicant needs paratransit door to door service. We need detailed information about how the condition or disability makes it functionally impossible for the applicant to utilize our regular fixed route bus service. Our evaluation is a transportation decision, not a medical authorization.

The law is very specific as to whom and under what circumstances eligibility may be granted to use Iowa City Transit's ADA Paratransit transportation.

All Iowa City Transit buses have ACCESSIBLE features:

- All are equipped with wheelchair lifts or ramps, along with securement devices.
- Most buses have a kneeling capability. (Can be lowered to provide easier boarding)
- Approximately 50% of the buses have only one step up from the curb.
- Bus operators announce transfer points and all requested stops.
- Customer Service phone line(s) are available to provide bus schedule information and assist customers with their trip routing, including transfers between bus routes.

IOWA CITY TRANSIT
319-356-5151
335 IOWA AVENUE
IOWA CITY, IA 52240

Medical/Professional Verification

(Not a request for copies of medical records)

Applicant's Name: _____

1. Please indicate date of your most recent examination of this applicant:_____/_____/_____

2. Does the applicant have the Mental Capacity to:

Give addresses and phone numbers?	[ ] Yes [ ] No
Recognize a destination or landmark?	[ ] Yes [ ] No
Deal with unexpected change(s) in routine?	[ ] Yes [ ] No
Ask for, understand and follow directions?	[ ] Yes [ ] No
Travel safely/effectively through crowded or complex facilities?	[ ] Yes [ ] No

3. Specify which functional limitations are associated with this applicant's condition(check all that apply):

[ ] mobility impairment [ ] cognitive impairment** [ ] compromised endurance
[ ] muscular [ ] respiratory [ ] other_____
[ ] visual impairment [ ] total [ ] partial
[ ] hearing impairment [ ] total [ ] partial

**If this individual has a cognitive impairment, please indicate all that apply to this individual:

[ ] Cannot be left alone to wait for transportation
[ ] Displays behavior that is unsafe for self or others using public transportation
[ ] Cannot recognize vehicles that she/he should board

4. What is the expected duration of this individual's condition?

[ ] < 3 months [ ] 3 – 6 months [ ] 6 – 12 months
[ ] 12 – 24 months [ ] Permanent condition

5. Does the applicant use a mobility device? Please check all that apply.

[ ] cane [ ] extra-large wheelchair [ ] prosthesis
[ ] long white cane [ ] power wheelchair [ ] communication board
[ ] portable oxygen [ ] manual wheelchair [ ] other_____
[ ] walker [ ] power scooter/cart [ ] none
[ ] crutches [ ] service animal [ ] unknown

6. How far can the applicant travel to/from a bus stop or destination? Please check.

Walking without assistance		**Using Mobility Device**
[ ] Unable to travel any distance		[ ] Unable to travel any distance
[ ] The length of one football field?	(300 feet)	[ ] The length of one football field?
[ ] Less than one city block?	(500 feet)	[ ] Less than one city block?
[ ] One length of a football field and back?	(600 feet)	[ ] One length of a football field and back?
[ ] One lap around a track?	(1,320 feet)	[ ] One lap around a track?

7. How long can the applicant wait outside at a bus stop?

	Sitting	**Standing**	**Using Mobility Device**
Unable to wait	[ ]	[ ]	[ ]
0 – 5 minutes	[ ]	[ ]	[ ]
5 – 10 minutes	[ ]	[ ]	[ ]
10 – 20 minutes	[ ]	[ ]	[ ]
20 + minutes	[ ]	[ ]	[ ]

8. Does the disability/condition prevent the applicant from riding a wheelchair accessible bus?
[ ] Yes
[ ] No
[ ] Sometimes; explain_____

9. Does weather affect the applicant's ability to travel?
[ ] Yes
[ ] No
[ ] Sometimes; explain_____

10. Does the applicant have medically defined temperature sensitivity? [ ] Yes [ ] No

Above what temperature for heat sensitivity? _____

Below what temperature for cold sensitivity? _____

Does the Applicant require a Personal Care Attendant when traveling? [ ] Yes [ ] No

A Personal Care Attendant (PCA) is not a companion or escort, but someone who will be help the client with his/her mobility assistance, personal care, communication, transportation, sign language interpretation, providing services as a reader, etc., as the client makes his/her trip.

Visual Impairment Verification *(If Applicable)*

(Not a request for copies of medical records)
Please describe the applicant's disability/condition in layman's terminology:

_____

How long has the applicant had this visual impairment? _____

Is the applicant's visual impairment permanent? [ ] Yes [ ] No

Does the visual impairment prevent applicant from riding a wheelchair accessible bus? [ ] Yes [ ] No

Hearing Impairment Verification *(If Applicable)*

(Not a request for copies of medical records)

Please describe the applicant's disability/condition in layman's terminology:

_____

Does the hearing impairment prevent applicant from riding a wheelchair accessible bus? [ ] Yes [ ] No

Cognitive Impairment Verification *(If Applicable)*

(Not a request for copies of medical records)

Please describe the applicant's disability/condition in layman's terminology:

_____

What was the onset date of these conditions? (Month/year) _____

If temporary, what is the expected duration of this individual's condition?

[ ] < 3 months [ ] 3 – 6 months [ ] 6 – 12 months
[ ] 12 – 24 months [ ] Permanent condition

CERTIFICATION:

I certify that the information I have provided herein is a fair representation of this applicant's medical impairment or condition and is accurate to the best of my knowledge. I understand the information provided hereto will be used for the sole purpose of determining the applicant's eligibility for paratransit services. I also agree that Iowa City Transit may contact me for clarification of any information I have provided and I will reply in good faith. I certify that the information contained herein is true and correct to the best of my knowledge and ability.

Health Care Professional Completing Form (name):_____

Medical License Number: _____ Telephone: _____ Fax: _____

Institution/Facility/Agency Name_____

Street_____ City_____ State_____ Zip Code_____

Signature of Health Care Professional_____

Iowa City Transit Office Use Only

Date Certification Received_____/_____/_____ Certification Date:_____/_____/_____

Type
Conditional Eligibility _____

Unconditional Eligibility_____

Temporary Eligibility_____

Date Certification Denied_____/_____/_____
Denied Reason:

_____

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_____

Appeal Received Date: _____/_____/_____ MPOJC Received Date:_____/_____/_____

MPOJC Decision:_____ Date:_____/_____/_____

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