TOLEDO AREA REGIONAL TRANSIT AUTHORITY PARATRANSIT ELIGIBILITY APPLICATION

INTRODUCTORY INFORMATION

The Americans with Disabilities Act (ADA) was passed in 1990. This federal law states that the regular transit bus system (fixed route) should serve as a primary means of transportation for everyone, including people with disabilities. The intent was to remove barriers that have prevented people with disabilities from fully participating in life, including barriers to public transportation.

TARTA Move, a shared-ride Paratransit service, is available for those individuals whose disabilities in combination with their functional abilities prevent them from using the regular ADA transit bus system *(TARTA fixed-route*) for some or all of their transportation needs. Services are provided by both TARTA Move drivers and local contracted transportation providers.

TARTA Move covers the same service area as TARTA fixed route, in addition to a three-quarter of a mile buffer around those routes. Rides on TARTA Move must be reserved one (1) to seven (7) days in advance. TARTA Move operates with a 30-minute window of arrival, meaning your ride may arrive 10 minutes earlier or 20 minutes later than the designated pick-up time. When rides arrive within this 30-minute window, they are considered on time.

Please keep in mind that TARTA Move is a shared ride service. Other TARTA Move riders may be picked up or dropped off before you reach your destination.

Eligibility is NOT based on:

- Age, Gender, or Race.
- A disability or medical diagnosis alone (ex: schizophrenia, cerebral palsy).
- The use of a mobility aid (ex: wheelchair, walker).
- An inability to drive.
- Personal finances.
- Neighborhood safety/crime concerns.
- Inconvenient *TARTA* fixed route bus schedules.
- Not being able to carry items on the bus (ex: books, groceries, strollers).
- Not knowing how to use the TARTA fixed route bus system

KEEP THIS INFORMATION PAGE FOR YOUR RECORDS - DO NOT SEND WITH YOUR APPLICATION

INSTRUCTIONS FOR COMPLETING THIS ELIGIBILITY APPLICATION

This application is to be completed by the person requesting ADA Paratransit Service (or helper). Please read the definitions of eligibility in the first paragraph of the Introductory Information page carefully and consider how your disability prevents you from using *TARTA fixed routes*. Please answer each question as completely as possible. Incomplete applications will be returned for clarification, and this will delay your eligibility determination. Both PART I and PART II are required to be completed in order for this application to be processed. The applicant or the parent, legal guardian of a minor, or POA must sign all applications. Children under the age of 18 should be accompanied by a parent, legal guardian, or designated adult for assessments. TARTA Move reserves the right to request that applicants have someone to accompany them.

You may include additional medical diagnosis or verification forms and health information releases as you deem necessary. Additional forms may be downloaded from the TARTA website at: www.tarta.com/services/move. If you have any questions, please call the Customer Service Representatives at 419-382-9901, Monday – Sunday 9am to 5pm. For Ohio Relay service, please call 1-800-750-0750, Monday – Sunday 9am to 5pm.

Completed applications should be submitted to the TARTA Paratransit Office by mail, fax, or email.

TARTA Move
130 Knapp St.
Toledo, OH 43604
419- 724-6659(Fax)
move-eligibility@tarta.com (E-mail)

THE NEXT STEP

After your application is received, you may be contacted for an in-person assessment or phone review. You can request a free, round-trip TARTA Move ride for the assessment as long as you can arrange pick-up within the TARTA Move service area. The purpose of this assessment is to review your application with you, assess information and capabilities as they pertain to ADA eligibility, and determine if additional information is needed.

All applicants will have their pictures taken. You will receive a notice by mail of your eligibility status for the TARTA Move ADA Paratransit Service. If a decision regarding your eligibility has not been made within 21 business days, you may request an extension of service until the determination is made and you are notified. Per ADA regulation, TARTA is required to make an eligibility determination within 21 business days of receiving a complete application. This timeframe does not include days out of the office, vacation, holidays, or days spent waiting for information to be sent to the Eligibility Department.

ELIGIBILITY STATUS

The eligibility period ranges from less than 1 to 5 years. Riders need to reapply for certification when eligibility expires and are encouraged to submit recertification applications three (3) months in advance. Eligibility may be granted upon the following basis:

--**Unconditional** - all trips within the service area.
--**Temporary** - for a shorter defined period (less than one year) as limitations or medical conditions are expected to change.

DENIALS / APPEALS

To appeal denials or temporary eligibility, the appeals process information will be included in the notification you receive from TARTA Move of your status. Paperwork must be filed within 60 calendar days of notification.

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Toledo Area Regional Transit Authority
Paratransit (TARTA Move) Eligibility Application

PART I

SECTION 1: GENERAL INFORMATION

Title: ☐Mr. ☐Mrs. ☐Ms.

Last Name:_____First Name: _____ MI_____

Street Address:_____Apt. #: _____

Facility/Apartment Complex Name:_____

City:_____State:_____Zip Code:_____

Email address:_____

Phone: (Primary) (_____)_____-_____(Secondary) (_____)_____-_____

Last four digits of S.S. number _____ Birth date: ____/____/____

It is your responsibility to notify Customer Service in the event your contact information or address should change.

Office Use Only

Which of the following best describes your ethnicity?

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Hispanic/Latino

☐ Native Hawaiian or another Pacific Islander

☐ Multiracial

☐ White

Are you a Lucas County Board of Developmental Disabilities client? ☐ Yes ☐ No

May we leave detailed messages about your application or recertification?

Via phone: ☐ Yes ☐ No Via email: ☐ Yes ☐ No

All information regarding TARTA Move is provided in writing unless otherwise specified. Do you need information given to you in another format? Specify _____

EMERGENCY CONTACT INFORMATION

Please list the names and telephone numbers of 2 people to call in case of an emergency:

Name: _____

Relationship: _____

Phone: (Primary) (____) ____ - ____(Secondary) (____) ____ - ____

Name: _____

Relationship: _____

Phone: (Primary) (____) ____ - ____(Secondary) (____) ____ - ____

Designated Contact:

May we contact this person if we have any questions regarding your application? ☐ Yes ☐ No

Name: _____Phone Number: (____) ____ - ____

Relationship to you: _____Agency name, if professional: _____

Please check the line that best describes your current living situation:

☐ 24-hour care or skilled nursing facility.

☐ Assisted living facility.

☐ I receive agency assistance from someone who comes to my home to help with daily living activities or medical care. List help provided:_____

☐ I receive help from family members or friends. List help provided: _____

☐ I live independently (without the assistance of another person).

SECTION 2: INFORMATION ABOUT YOUR DISABILITY

1. How far can you travel on a flat surface, either on your own or using your regular mobility aid, without the assistance of another person?

   ☐ Not able to travel at all without assistance from another person.
   ☐ One Block (.10 mi. or 528 ft.)
   ☐ Two blocks (.20 mi. or 1056 ft.)
   ☐ Three blocks (.30 mi. or 1584 ft.)

2. What is the primary mobility device(s) you use for outdoor travel? Check all that apply:

   ☐ Portable oxygen
   ☐ Service animal
   ☐ Prosthetic limb
   ☐ Crutches
   ☐ Leg brace
   ☐ Straight cane
   ☐ White cane
   ☐ 3–4-pronged cane
   ☐ Manual wheelchair
   ☐ Power wheelchair
   ☐ Leg extender on wheelchair
   ☐ Power scooter
   ☐ Folding walker
   ☐ Non-folding walker
   ☐ Walker with seat
   ☐ Walker with wheels
   ☐ Communication board
   ☐ Hearing aids
   ☐ Visual assistance aids – please list: _____
   _____
   ☐ Other (be specific)
   _____
   _____

3. ***If applicable:*** My wheelchair, scooter or walker is oversized to accommodate my needs.

   ☐ Yes ☐ No

   If yes, you may be required to provide a PCA (Personal Care Attendant) to assist with boarding and exiting the vehicle.

4. What is *the primary disability or health condition(s)* that prevent you from using *TARTA Fixed Route service* for some or all your trips? Please be specific.

   _____
   _____
   _____
   _____

5. Do the effects of your disability or conditions vary from day to day? ☐ Yes ☐ No

   If yes, please explain: _____

   _____

6. My disability is: _____Permanent _____Temporary -- For how long? _____

   If temporary, please explain: _____

   _____

SECTION 4: THE ENVIRONMENT AROUND YOUR HOME AND TO THE CLOSEST BUS STOP

1. In your own words, describe the area between where you live and the closest bus stop. (Describe: sidewalks, visibility, roadway traffic, temporary construction, traffic signals, curbs, business, terrain and anything else you think is noteworthy.)

   _____

   _____

   _____

2. Is the entrance to your home ADA accessible? ☐ Yes ☐ No

3. If yes, please describe (ramps, railings, steps, lighting, sidewalks)

   _____

   _____

   _____

SECTION 5: YOUR CURRENT TRAVEL NEEDS

1. Currently, how do you get to the places you need to go outside your home?

   _____

   _____

   _____

2. List 3 of your most frequent travel destinations.

   _____

   _____

   _____

3. Would you be interested in getting information about travel training? ☐ Yes ☐ No

SECTION 6: AUTHORIZATION TO RELEASE PROTECTED HEALTH INFO

I authorize the use or disclosure of the protected health information (PHI) as described below. By authorizing the use or disclosure of the PHI described below, I authorize the provider (doctor, social services, etc.) of the PHI (1) to open the PHI for review or inspection by the person(s) identified below, and (2) to furnish the persons(s) identified below with a copy of the PHI if he or she requests, for purposes of determining my eligibility to receive transportation services.

Date _____ Patient (Applicant) Name _____

DOB _____ Social Security Number (last 4 digits) _____

Description of PHI requested, including information pertaining to:

(1) The applicant's documented diagnosis/health condition(s) & how these affect his/her ability to independently use the fixed route bus service.
(2) Written and/or verbal communication between provider and TARTA Move.

I authorize the following provider (doctor, social services, etc.) of my PHI to release and/or disclose the PHI described above:

Provider_____

Address_____

Phone Number _____ Fax Number _____

I authorize the release and/or disclosure of the PHI described above to:

Toledo Area Regional Transit Authority, Paratransit Eligibility Dept.

130 Knapp Street TEL: 419-382-9901 FAX: 419-724-6659

Toledo, Ohio 43604 EMAIL: move-eligibility@tarta.com

I, the applicant, authorize the provider to disclose the PHI described. ☐ Yes ☐ No

I understand that I have the right to revoke this Authorization, in writing, at any time by so notifying the requesting person. Such revocation will not affect the actions taken by the requesting person prior to the date he or she received the written revocation.

I understand that my health care provider cannot condition medical treatment on whether I sign this

Authorization. This Authorization will expire at the conclusion of my Paratransit Eligibility Review.

X_____ _____

Signature of Applicant Date

X_____ _____

Signature of Parent/Guardian/Authorized Representative Date

_____

Relationship to the Applicant

NOTE: A Photocopy or facsimile shall have the same effect as the original.

SECTION 7: APPLICANT'S CERTIFICATION

In compliance with the Americans with Disabilities Act of 1990 (ADA), *TARTA* provides Paratransit service (other than the regular bus service) to anyone with a disability, who qualifies and who cannot use the fixed route bus system and who is traveling within ¾ mile of a scheduled fixed route. This shared-ride service is intended only for those trips that the rider cannot make on the fixed route system.

This application is intended to determine when and under what circumstances the applicant can use the shared-ride ADA Paratransit service.

I understand that the purpose of this application is to determine if there are times when I cannot use the fixed route or TARTA Flex bus system and will need to use the shared-ride Paratransit system.

I understand that all the information concerning my disability will be kept confidential and shared only with professionals that will be involved in the determination of my eligibility.

I authorize any professional organization and/or designated contact listed in this application to release information relating to my disability to the TARTA Move office in order to determine eligibility.

I certify that, to the best of my knowledge, all the information in this application is true and correct. **In the event of the change in contact information or address, it is my responsibility to notify TARTA Move.** I understand that providing false information could result in the loss of Paratransit Services. I agree to notify TARTA Move if my condition improves enough to change my eligibility status.

SIGNATURE: Please Complete Part A or B

Part A. Applicant:

_____

Signature of Applicant **Date**

Part B. Applicant is a minor, or has a guardian:

I consent to the Applicant's interview and any assessments of their travel abilities and limitations to determine ADA Paratransit Service eligibility. I understand that the Applicant and parent/legal guardian or other designee must be present for the interview/assessment process, and I acknowledge the following:

_____

Name Relationship to Applicant

_____

Address

Phone_____ Org/Agency _____

☐ I will be present ☐ I designate_____ to be present on my behalf

_____

Guardian's Signature Date

_____

Applicant's Signature Date

TARTA MOVE APPLICATION: PART II

This form MUST be completed by a Clinical Professional

Examples of who can complete Part II [must be licensed/certified]:
To the Clinical Professional completing this form:

Audiologist
Case/Resource Manager
Chiropractor
Independent Living Specialist
Nurse Practitioner
O & M Instructor
Ophthalmologist
Optometrist
Physical Therapist
Physician
Physician's Assistant
Occupational Therapist
Psychologist
Registered Nurse
Respiratory Therapist
Psychiatrist
Vocational Rehabilitation Specialist
Social Worker
Job Training Coordinator

The individual presenting this form to you is applying for TARTA Move Paratransit Services. This is federally mandated by the ADA (Americans with Disabilities Act). It is a door-to-door, shared-ride service on specially equipped buses for individuals whose disability **prevents** them from using the regular bus transit system (*TARTA Fixed route*) under certain circumstances or all of the time. This does **not** include those who find it uncomfortable or inconvenient to ride a *TARTA Fixed route service*.

Only professionals who have knowledge of the applicant's functional ability or limitations to use the regular bus transit system (*TARTA*) should complete this form. Please assist us in determining this individual's eligibility for the use of the TARTA Move Paratransit Service. You may attach any additional information you think will help with the determination process.

***Please be aware that all *TARTA* buses are 100% accessible for individuals with disabilities. ***

In completing the application, consider that *TARTA* buses are equipped with:

- Low floor entrances on large buses which will eliminate multiple steps.
- Kneeling features on large buses that lower the bus to the same height as the curb.
- Ramps that can be deployed over sidewalks for no-step or wheelchair boarding on large buses.
- On smaller buses, wheelchair lifts to use as an alternative to steps.
- Outside real bus arrival displays at some locations.
- Interior scrolling displays and audio announcements that indicate date, time, intersections and safety announcements.
- Designated priority seating near the driver for passengers with disabilities and seniors.
- Wheelchair seating locations and wheelchair securement devices in priority areas.
- Bus Operators will assist with boarding and exiting by deploying ramps and secure mobility devices, such as wheelchairs and scooters.

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TARTA MOVE APPLICATION: PART II

To be completed by a Licensed/Certified Clinical Professional who has knowledge about the applicant's functional ability and can verify diagnoses. He/she does not have to be the one who provides treatment. ONLY THE PROFESSIONAL COMPLETES THIS PART II.

Applicant Name

Required Information – Licensed/Certified Clinical Professional

Name_____ Title _____

Signature **X**_____ Date_____

Professional License # _____

Clinic or Agency _____

Address _____

Phone Number _____ Fax # _____

E-mail (optional) _____

Please list all related diagnoses that affect the applicant's ability to travel in the community. List the specific diagnosis and its severity in each category. Complete each of the following sections as they apply to the applicant. (You don't need to be the one who treats the diagnosis but can verify the diagnosis and how it impacts the applicant.)

Physical Diagnoses _____

_____

Cognitive Diagnoses _____

_____

Mental Health Diagnoses _____

_____

Vision Diagnoses _____

_____

Date of last evaluation: _____ Patient/Client since: _____

Is the condition(s) temporary? ☐ Yes ☐ No If yes, what is the expected duration? _____

Describe the temporary condition: _____

Physical Disabilities – Does the diagnosis(es) impact travel?

☐ **Yes (Complete section)** ☐ **No** / ☐ **N/A (Continue to next page.)**

1. Does the applicant rely on any mobility aids/equipment for outdoor travel? ☐ Yes ☐ No

   If yes, please indicate what kind: _____

2. How far can the applicant independently **propel a manual/power wheelchair or ambulate with or without a mobility aid and without lengthy rest breaks?** (Endurance standards: 6.4 minutes/block; 32 minutes/5 blocks or ½ mile)

   _____ 1-2 blocks _____ # of blocks (528 feet = 1 block)

   _____ 3 or more blocks _____ No independent functional mobility (needs assistance)

3. Are there any issues regarding coordination, balance, gait or speed that would affect the applicant's ability to get to bus stops on varying terrains and surfaces, or ride on a moving bus? If so, please list functional impact.

   _____

   _____

4. If there is a seizure disorder, what type(s) of seizures?… frequency?. ..... last known seizure?

   _____

   Are the seizures currently controlled? ☐ Yes ☐ No

   Is the applicant taking medicine for the seizures? ☐ Yes ☐ No

   Is he/she able to function independently in the community? ☐ Yes ☐ No

5. Additional Comments/Barriers or side effects: _____

   _____

Cognitive Disabilities – Does the diagnosis(es) impact travel?

☐ **Yes (Complete section)** ☐ **No** / ☐ **N/A (Continue to next page.)**

1. Can the applicant provide basic information about his name, address, phone number? ☐ Yes ☐ No

2. Does the applicant have the ability to:

   a. Identify dates? ☐ Yes ☐ No

   b. Recognize time on a watch or phone? ☐ Yes ☐ No

   c. Understand time concepts well enough to follow a schedule to get to places on time? ☐ Yes ☐ No

   d. Be left unattended? ☐ Yes ☐ No

      If yes, duration:_____

3. Can the applicant recognize familiar words, phrases, and destinations? ☐ Yes ☐ No

4. Which of the following impacts the applicant's ability to use TARTA Fixed route services? Please check all that apply to the applicant and **provide additional information for categories selected.**

   ☐ Problem Solving ☐ Communication of Needs ☐ Coping

   ☐ Process Information ☐ Safety Awareness/Judgment ☐ Concentration

   ☐ Social Skills/Behavior ☐ Other _____

   _____

   _____

   _____

   _____

5. Additional concerns/ comments: _____

   _____

Mental Health Disabilities – Does the diagnosis(es) impact travel?

☐ **Yes (Complete section)** ☐ **No** / ☐ **N/A (Continue to next page.)**

1. What is the prognosis? (stable, guarded, etc.)

   _____

2. If taking medicine, are there side effects that can affect travel in the community? ☐ Yes ☐ No

   Explain:

   _____

3. Has the applicant recently had a decline in function affecting treatment plan, medications or any other factors that may complicate travel? ☐ Yes ☐ No

   Explain: _____

4. Would any of the following affect the applicant's ability to use TARTA Fixed route services?
   Provide additional information for categories selected.

   ☐ Problem Solving ☐ Communicate Needs ☐ Coping

   ☐ Processing Information ☐ Safety Awareness/Judgment ☐ Concentration

   ☐ Social Behavior/Skills ☐ Other _____

   _____

   _____

   _____

5. Additional concerns/ comments: _____

   _____

Vision Disabilities – Does the diagnosis(es) impact travel?

☐ **Yes (Complete section)** ☐ **No** / ☐ **N/A (Continue to next page.)**

Applicant's condition: Legally Blind ☐ Yes ☐ No

☐ Total Blindness ☐ Light Perception

☐ Reduced Acuity
(L) _____ (R) _____ (best corrected)

☐ Restricted Field of Vision
(L) _____ (R) _____

☐ Central field loss ☐ Peripheral field loss

☐ Other _____

1. What is the prognosis? Is the condition stable, degenerative, or otherwise changing?

_____

2. Is his/her vision affected by different lighting conditions? ☐ Yes ☐ No

☐ Bright sunlight ☐ Dimly lit or shaded places

☐ Nighttime ☐ Other _____

3. Additional comments regarding applicants' independent outdoor travel abilities:

_____

_____

_____

Professional Recommendation

1. Do you expect the applicant could independently utilize the **TARTA Fixed route services?** This would **include traveling to/from stops or destinations and waiting for the bus**. Note: Individuals can request travel training through *TARTA*.

   ☐ Yes, could ride ***TARTA Fixed route*** ☐ No, utilizing ***TARTA Fixed route*** is not appropriate

2. Is there any other information you want to provide that will help us in making an appropriate eligibility determination?

   _____

   _____

   _____

We greatly appreciate your time in completing this application.

Please send to:

TARTA Move Mobility Services Department
130 Knapp Street
Toledo, OH 43604
419-382-9901 (phone)
419-724-6659 (fax)
Email: move-eligibility@tarta.com

Additional applications may be downloaded at the TARTA website (tarta.com) under Services/Move