Cape Cod Regional Transit Authority

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Application for Cape Cod Regional Transit Authority Door-to-Door Paratransit and Reduced Fare Service For People with Disabilities

PLEASE MAIL OR FAX APPLICATIONS

Thank you for your interest in the Cape Cod Regional Transit Authority (CCRTA) services for people with disabilities. The following services are available based on CCRTA's determination of your eligibility:

(A) Reduced Fixed Route or Demand Response (DART) Fare Program for People with Disabilities – Eligible people with disabilities travel on accessible CCRTA fixed route buses for half the regular fare at all times. This program is available for people with disabilities who use the accessible fixed route Cape Cod Regional Transit Authority system as their primary travel option.

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(B) ADA Paratransit – Door-to-door, shared ride public paratransit service for people with disabilities who are unable to use regular accessible fixed route public transportation for some or all of their public transportation due to a disability. The Americans with Disabilities Act (ADA) outlines specific criteria to determine eligibility for paratransit service and an application is required The Cape Cod Regional Transit Authority ADA Paratransit service operates in all fifteen towns on Cape Cod within ¾ mile of our fixed route services.

To apply for either of these services you and your healthcare provider must complete this application. Please read and follow the instructions on the following page.

Instructions

Step 1: Applicants should read the entire application and complete Part A only.

Step 2: Take the entire application to a **healthcare provider holding active licensure or credentials in the area of your disability** to complete Part B. One of the following health care providers must certify the application: Physician, Physician's Assistant, Certified Nurse Practitioner, Optometrist (visual disabilities only), Podiatrist (disabilities of the foot and ankle only) or, Licensed Clinical Psychologist (psychiatric disabilities only). It is your responsibility to ensure the original signed and completed application is received by the Cape Cod Regional Transit Authority ADA Coordinator at the address on Page One.

Step 3: The CCRTA will determine your eligibility based on how your disability impacts your functional abilities to use the accessible fixed route public transportation system. Financial need is not a criterion for ADA Paratransit eligibility. Please note that the minimum age to apply for the service is 5 years old. The office is open Monday - Friday from 8:30 AM - 4:30 PM. Hours are subject to change without notice so please call in advance. Phone lines open at 8:30 AM, Monday through Friday.

PART A: Applicant Information and Release

Last Name:

First Name: **Middle Initial:**

Address: **Apt#:**

City, State, Zip:

Gender: ☐ Male ☐ Female **Date of Birth:** _____/_____/_____

Email:

Primary phone: ( ) ☐ Home ☐ Cell ☐ Work

Secondary phone: ( ) ☐ Home ☐ Cell ☐ Work

In case of an emergency, who should be notified?

Name:

Relationship: **Phone:** ( )

Mobility Devices: Do you require the use of a mobility device when traveling?

☐ No ☐ Yes

Check all that apply: ☐ Manual Wheelchair ☐ Support Cane

☐ Portable Oxygen ☐ Power Wheelchair or Scooter
(up to 48"x30" and no more than 800 pounds when occupied)

☐ Crutches ☐ Walker ☐ White Cane *(for visually impaired)*

☐ Other:

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PART A: Applicant Information and Release

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Do you use a service animal? ☐ No ☐ Yes ☐ Sometimes

If yes, please describe the type of animal and what service(s) the animal was trained to perform:

I certify that all information contained in part A of this application was completed by me or my appointed representative and is true.

Original Signature of Applicant:

(Under 18, Signature of Parent or Guardian)

Date:

Authorization to help me apply for services

Please complete the authorization below if you are providing legal authority to another party to complete this application and act as your agent in the processing of this application.

***** This form is only to be used when an applicant is not able to otherwise give consent for assistance and information sharing.***

Applicant's Name: _____

Applicant's Address: _____

_____

I would like to apply for CCRTA door to door paratransit service.

I am appointing_____to help me apply. For this purpose only, he or she has the authority to act on my behalf, including scheduling appointments, completing paperwork, and providing information about me to the CCRTA, so long as it relates to my application for this service. CCRTA may release any information it has about me upon request, to this person, including health care information, so long as it relates to my application for services. For this purpose only, my agent may request, receive, and review any information, oral or written, regarding my physical or mental health, including but not limited to, medical and hospital

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Authorization to help me apply for services

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records and other protected health information, and consent to disclosure of this information.

For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA) and is entitled to request, receive, and review protected health information: any information, oral or written, regarding my physical or mental health, including but not limited to medical and hospital records, and other protected health information. My agent may also consent to disclosure of this information.

This agreement expires: (Select one from options below.)

☐ At the end of my CCRTA certification process; or

☐ At the end of my CCRTA certification and any applicable appeal process.

In any event, this agreement would expire no later than one year from when it is signed. I can cancel this agreement at any time by telling the person and calling CCRTA to inform them that this authorization is no longer valid.

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Authorization to help me apply for services

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Signature: _____

Date: _____

Printed Name: _____

I, _____ , agree to help _____
(Agent's Name) *(Applicant's Name)*

with his / her application for the Cape Cod Regional Transit Authority. Either I, or another person from my organization, will come with the applicant to their eligibility appointment and assist him / her.

Signature: _____

Date: _____

Printed Name: _____

Applicant's HIPAA Authorization

I, _____ , authorize the healthcare provider completing this application to release to the Cape Cod Regional Transit Authority any protected health information about my disability in order to verify my eligibility for CCRTA Paratransit Service for People with Disabilities. I also authorize the release of further information should it be needed for this application for a period of 60 days from the date of my signature on part A of this application.

Applicant's Signature: _____

PART B: Health Care Provider Certification

A healthcare provider holding active licensure or credentials in the area of the applicant's disability or the applicant's primary care provider as outlined on page 2 must complete Part B.

For the purpose of this application, eligibility is defined as any person with a disability who is unable, as a result of a physical or mental impairment to board, ride or disembark from an accessible vehicle independently or complete transfers without the assistance of another individual.

And/or

Any person with a disability who has a specific impairment related condition that prevents them from traveling to and from a bus stop on the public bus system. Architectural and environmental barriers such as distance, terrain or weather do not, standing alone, form a basis for eligibility. However, consideration should be given to the interaction of environmental conditions (terrain and weather) with the individual's impairment related condition.

Your patient has requested eligibility for CCRTA ADA services. This service provides a door to door, shared ride paratransit service for people whose disability(ies) prevent them from riding the fixed route accessible system, all or part of the time. As the applicant's healthcare provider you are uniquely qualified to clarify his or her

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PART B: Health Care Provider Certification

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functional abilities and limitations to ride the CCRTA's accessible bus system. In order to determine this applicant's functional abilities we require that you the healthcare provider not the applicant complete and certify all of the following sections. Please detail how the applicant's disability(ies) impact their ability to board, navigate and travel independently on the accessible fixed route system. Please be as specific as possible.

1. Name of Health Care Provider: (Please print):

2. Phone: ( )

3. License Number/State Issued:

4. Street Address & Suite #:

5. City, State, Zip:

6. Specialization:

7. Written Diagnosis(es) and ICD-9CM and/or DSM Code(s):

8. If applicant has a seizure disorder or epilepsy, have they had a tonic-clonic seizure within the past 4 months? ☐ No ☐ Yes ☐ N/A

9. Does the applicant require a Personal Care Attendant (PCA) when traveling on public transportation? ☐ No ☐ Yes

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PART B: Health Care Provider Certification

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10. Does the applicant require any of the following mobility aids listed in question 11?
☐ No ☐ Yes

11. Check all that apply: ☐ Manual Wheelchair ☐ Support Cane
☐ Portable Oxygen ☐ Power Wheelchair or Scooter ☐ Crutches ☐ Walker
☐ White Cane (visually impaired) ☐ Other: _____

12. What is the expected duration of the disability? *(Please initial appropriate line below)*

_____**Short-Term**
Conditions that last at least 90 days, but are likely to improve within one year.

_____**Long-Term**
Conditions with absolutely little expectation of improvement

13. Does this applicant's disability(ies) prevent him/her from independently using the accessible CCRTA Fixed Route System? ☐ No ☐ Yes

If yes, HOW does the disability or health condition impact the applicant's ability to travel independently from one location to another on the accessible CCRTA Fixed Route System?

_____

_____

_____

_____

_____

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PART B: Health Care Provider Certification

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14. If this applicant is currently on medication(s), will the side effects of this significantly reduce or hinder his/her ability to independently ride the accessible CCRTA Fixed Route System? ☐ No ☐ Yes ☐ N/A

If you selected ***yes*** for this question, please explain how the side effects would hinder this applicant's ability to use the accessible fixed route bus system:

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PART B: Health Care Provider Certification

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Environmental Issues that affect the applicant

Based on the applicant's disability(ies), please tell us if the following environmental factors affect his/ her ability to ride CCRTA's accessible bus system.

15. Would extremes in temperature affect this applicant's ability to ride the accessible fixed route system? ☐ No ☐ Yes

If yes, please explain the effect and the extent of the limitation(s):

_____

_____

_____

16. Would ice and/or snow affect this applicant's ability to ride the accessible fixed route system? ☐ No ☐ Yes

If yes, please explain the effect and the extent of the limitation(s):

_____

_____

_____

17. Would poor air quality affect this applicant's ability to ride the accessible fixed route system? ☐ No ☐ Yes

If yes please explain the effect and the extent of the limitation(s).

NOTE: If applicant suffers from Asthma, please indicate if the applicant has been on systemic medication for the immediate past 6 months OR has been required to use fast acting inhalers for three or more episodes per week for the immediate past six months.

_____

_____

_____

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PART B: Health Care Provider Certification

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Environmental Issues that affect the applicant

Based on the applicant's disability(ies), please tell us if the following environmental factors affect his/ her ability to ride CCRTA's accessible bus system.

18. In your medical opinion what other factors related to the applicant's disability(ies) affect his/her ability to ride the accessible CCRTA fixed route system?

_____

_____

_____

_____

Health Care Provider Signature Page

I certify that I have completed the questions in Part B and that the information provided is correct.

Original Signature of Physician /Healthcare Provider:

_____

(Note: Must be original hand signature, not signature stamp)

Printed Name: _____

Date: _____

The Cape Cod Regional Transit Authority reserves the right to: (1) verify the validity of the license of the health care provider providing the certification, (2) make the final determination on an applicant's eligibility for services for people with disabilities, and (3) retain a copy of this application.