



## *LEWISTON TRANSIT SYSTEM*

In accordance with the Americans with Disabilities Act (ADA) of 1990, Lewiston Transit System provides complimentary Para transit service, also known as “dial-a-ride”, to individuals with disabilities who are unable to use the available stops on our fixed route service.

The purpose of this application is to provide an opportunity for you to describe the effects of your disability and/or environmental barriers that prevent you from traveling independently and or getting to/from a bus stop. Disability alone does not determine eligibility. The decision is based on your functional ability to use the fixed route bus and is not based on a medical diagnosis. **PLEASE NOTE: Age, unfamiliarity with routes and/or distance to bus stops, an inability to drive, and time inconveniences are not determining factors that qualify for paratransit service.**

***The information that you provide will help LTS to understand your abilities and travel challenges. All information contained in this application will be kept confidential and shared only with the professionals involved in evaluating your eligibility.***

***All applicants must complete the application and provide written professional verification of disability. The ADA***

***certification process helps us determine which mobility services are appropriate for you based on your abilities.***

***All questions must be answered. Incomplete forms will be returned and cause time delays in processing your application. If you have questions or need assistance completing this form, please call the Transit Operations Supervisor at (208) 298-1340.***

***Lewiston Transit System's ADA eligibility process includes:***

***Receipt of your completed application, including professional verification (pages 8-9 of this packet). (Incomplete applications will be sent back to you and cause delays in processing).***

***Once we have received your completed application, LTS will process it within 21 days and notify you of our determination and provide you information on how to access our services.***

***If you have not heard from our office after 21 days, you will be granted Presumptive Eligibility. This will allow you to use dial-a-ride service until a final determination has been made.***

***Your notification will be sent to you in the form of a letter. If you disagree with the decision, you have 65 days from***

***the date on your determination letter to file the Request to Appeal form. After we receive your form:***

***Lewiston Transit System will review the additional information and make a final determination within thirty (30) days;***

***Or***

***You may request to present your additional information in-person to the ADA Eligibility Appeals Committee, who will make a determination within thirty (30) days. You may have someone accompany you.***

***Applications and/or appeals may be mailed to:***

***Lewiston Transit System  
ATTN: Transit Operations Supervisor  
PO Box 617  
Lewiston, ID 83501***

***Faxed to: (208) 298-1339***

***Delivered to: Lewiston Transit System  
215 D Street  
Lewiston, ID 83501***

***If you have not heard from us within 21 days, please contact the Transit Operations Supervisor at (208) 298-1340.***

## **APPLICANT INFORMATION**

**First Name:** \_\_\_\_\_

**Last Name:** \_\_\_\_\_ **Middle Initial** \_\_\_\_\_

**Home Address:** \_\_\_\_\_ **Apt#** \_\_\_\_\_

**Mailing Address (if different):**

\_\_\_\_\_

**City:** \_\_\_\_\_ **State** \_\_\_\_ **Zip Code:** \_\_\_\_\_

**Phone:** (    ) \_\_\_\_\_ **TTY:**     **Yes**     **No**

**Cell Phone:** (    ) \_\_\_\_\_ **TTY:**     **Yes**     **No**

**Birth Date:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Gender:**     **Male**     **Female**

**Do you need future written information provided to you in an accessible format?**     **Yes**     **No**

**If yes, please indicate your preferred format:**

**Computer Disc**     **Large Print**

**Emergency Contact:**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Phone:** (\_\_\_\_) \_\_\_\_\_ **Cell Phone:** (\_\_\_\_) \_\_\_\_\_

**Did anyone assist you with completing this application:**

**Yes**  **No**

**If yes, please provide the following information about the person:**

**Name:**

\_\_\_\_\_

**Phone:** ( ) \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Who is authorized to contact LTS on your behalf to schedule/cancel rides?**

**Name (individual or organization)**

\_\_\_\_\_

**Phone ( )** \_\_\_\_\_

**Name (individual or organization)**

\_\_\_\_\_

**Phone ( )** \_\_\_\_\_

***Your answers to questions in this section will help us better understand your functional ability in specific areas. Your answers should be based on your physical and mental ability to perform the tasks. Assume that you are using the mobility equipment that you usually use when traveling outside your home.***

***What type(s) of disabilities prevent you from using the fixed route service? Please check all that apply.***

***Physical Disability Impairment/Blindness***

***Visual***

***Developmental Disability***

***Brain Injury***

***Mental Illness***

***Other***

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***Does your disability prevent you from independently boarding, riding, or exiting from a bus?***

***Yes***    ***No***

***If yes, please identify your disability and/or environmental barriers that prevent you from traveling independently.***

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***Do you need the wheelchair lift to get on and off the bus?  
(This includes if you do not use a wheelchair/scooter, but  
will need the lift to board the bus).***

**Yes**     **No**

***If yes, please explain how your disability and/or  
environmental barriers prevent you from using a fixed  
route bus that has a wheelchair lift.***

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***Do you have a disability that prevents you from traveling  
to or from a bus stop?***

**Yes**     **No**

***If yes, please explain how your disability and/or  
environmental barriers prevent you from traveling to/from  
bus stops.***

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***Is your disability or health condition temporary or  
permanent?***

**Temporary (I expect my disability to last \_\_\_\_\_ months)**

**Permanent**

**Please describe ALL the mobility aid(s) or equipment you use, or will use, when traveling outside your home.**

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**IF YOU DO USE A WHEELCHAIR/SCOOTER, what is:**

**N/A**

**The width in inches?** \_\_\_\_\_

**The length in inches?** \_\_\_\_\_

**What is the make and model number of your wheelchair(s)/scooter(s)?**

**Make** \_\_\_\_\_ **Model Number** \_\_\_\_\_

**Make** \_\_\_\_\_ **Model Number** \_\_\_\_\_

**Make** \_\_\_\_\_ **Model Number** \_\_\_\_\_

**Do you have a wheelchair ramp at your home?**

**Yes**     **No**



***Do you, or will you, need the assistance of another person (PCA\*) to travel when using Dial-a-Ride? (\*A PCA is someone who provides assistance during your ride and/or at your destination, and has the same pickup and destination as you. A driver does not provide the services of a PCA.)***

**Yes**       **No**

***LTS offers FREE travel training that will help you become familiar with the routes. Would you be interested in this training?***

**Yes**       **No**

***Please list three (3) trips you travel most frequently:***

***Starting point address***

***Ending point address***

<b><i>(1)</i></b>	_____	_____
<b><i>(2)</i></b>	_____	_____
<b><i>(3)</i></b>	_____	_____

***If the weather is good and there are no environmental barriers, how far can you travel outside, independently, using your mobility device(s)?***

\_\_\_\_\_

***Please tell us anything else you would like us to know that affects your ability to board, exit or ride the fixed route.***

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***Privacy Statement***

***The information obtained in the application will only be used by the City of Lewiston and the Federal Transit Administration for the provision of public transit services. The information will be kept confidential and will not be provided to any other persons or agencies, unless authorized by the passenger and/or their legal guardian.***

***I certify that the information provided in this application is true and correct to the best of my knowledge. I authorize my health care provider and those named in the application to provide Lewiston Transit System information regarding my need for ADA paratransit service. I further understand that falsification of information may result in a denial of service.***

***Signature***

***Date***

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***Signature (if other than applicant) Relationship Date***

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**THE FOLLOWING PAGES TO BE COMPLETED BY A MEDICAL PROFESSIONAL**

**MEDICAL/PROFESSIONAL VERIFICATION**

Dear Professional:

Your patient is requesting qualification for ADA Priority transit service from Lewiston Transit System. To qualify, a person must be unable to use the fixed route due to a physical or mental disability. The information you provide about the noted disabilities will allow us to evaluate this request.

**PLEASE NOTE:** Age, unfamiliarity with routes and/or distance to bus stops, an inability to drive, and time inconveniences are not determining factors that qualify for Para transit service.

Please indicate below the nature of the applicant’s disability.

Please check your professional area of specialization:

- |  |  |
|--|--|
| <input type="checkbox"/> Audiologist               | <input type="checkbox"/> Registered Nurse/Licensed Practical Nurse |
| <input type="checkbox"/> Rehabilitation Specialist | <input type="checkbox"/> Physical/Occupational/Speech Therapist    |
| <input type="checkbox"/> Physician                 | <input type="checkbox"/> Independent Living Specialist             |
| <input type="checkbox"/> Optometrist               | <input type="checkbox"/> Psychologist                              |
| <input type="checkbox"/> Social Worker             | <input type="checkbox"/> Other _____                               |

Name \_\_\_\_\_ Title \_\_\_\_\_

Agency \_\_\_\_\_

License # (if applicable) \_\_\_\_\_

Agency address \_\_\_\_\_

Agency phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Patients Name \_\_\_\_\_

Patients Height \_\_\_\_\_ ft. \_\_\_\_\_ in

Patients Weight \_\_\_\_\_

**Please provide the ICD-10 diagnosis code(s) that correspond to the disabilities that prevent the patient's ability to use fixed route service.**

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**Please describe what physical and/or mental conditions exist that limits the applicant's ability to use the fixed route.**

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**Without assistance, how far can the applicant travel independently using their mobility aid?**

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**Please list current medications and describe the patient's medication plan.**

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**Does the medication plan effectively control the conditions for which they are prescribed?**

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**Please describe significant side effects of medication, if applicable.**

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Is the applicant's disability      Permanent      Temporary

If the applicant's disability is temporary, how long is the expected duration?

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**I hereby certify that the above information is true.**

Name (print) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_