LEWISTON TRANSIT SYSTEM

In accordance with the Americans with Disabilities Act (ADA) of 1990, Lewiston Transit System provides complimentary paratransit 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:

1. Receipt of your completed application, including professional verification (pages 7-8 of this packet). (***Incomplete applications will be sent back to you and cause delays in processing).***

2. 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.

3. 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.

4. 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: Fax: (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 Operation Supervisor at (208) 298-1340.

APPLICANT INFORMATION

First Name:____________________Last Name:____________________Middle Initial___

Home Address: ____Apt/Room #______

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.

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

   ❒Physical Disability ❒Visual Impairment/Blindness

   ❒Developmental Disability ❒Brain Injury

   ❒Mental Illness ❒Other ______________________

2. **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.

   ____

   ____

3. **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.

   ____

   ____

4. **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.

____
____

5. Is your disability or health condition temporary or permanent?

❒ Temporary (I expect my disability to last _____ months)

❒ Permanent

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

____
____
____

7. **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

8. **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

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

❒Yes ❒No

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

	Starting point address	Ending point address
(1)	______________________________	________________________________
(2)	______________________________	________________________________
(3)	______________________________	________________________________

11 If the weather is good and there are no environmental barriers, how far can you travel outside, independently?

____

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

____
____
____
____

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**

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

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 paratransit service.

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

Please check your professional area of specialization:

❒Audiologist
❒Rehabilitation Specialist
❒Physician
❒Optometrist
❒Social Worker
❒Registered Nurse/Licensed Practical Nurse
❒Physical/Occupational/Speech Therapist
❒Independent Living Specialist
❒Psychologist
❒Other ___________________________

Name ______________________________ Title ____________________

Agency ____

License # (if applicable) ____

Agency address ____

Agency phone (___)____________________ Fax (___)___________________

PATIENT INFORMATION

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.

____
____
____

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

____
____
____
____

How far can the applicant travel independently? If the applicant uses a mobility device, how far can they independently travel using their mobility device?

____

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

____
____
____
____

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

____
____
____

Please describe significant side effects of medication, if applicable.

____
____
____

Is the applicant's disability ❒Permanent ❒Temporary

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

____
____

I hereby certify that the above information is true.

Name (print) ____

Signature ___________________________________ Date ____________________