



PARATRANSIT SERVICES APPLICATION

Age or the inability to drive are not considered qualifying factors.

PART 1 – ELIGIBILITY APPLICATION

- Part 1 of the Application must be completed by the applicant or someone authorized to sign on the applicant's behalf.
- Please fill out Part 1, sections 1 through 5 of the application form. Please Print.
- After reading the Application Agreement and Release of Information, sign your application on page 6.

PART 2 – PROFESSIONAL VERIFICATION

- Sign the Medical Release/HIPPA Authorization on Page 1 of Part 2.
- Have your medical provider complete Part 2, Professional Verification, sections 1-4.
- Part 2 Section must be signed by a licensed medical or mental health professional.

Qualified medical professionals include licensed Medical Doctors, Physicians Assistant, Nurse Practitioner, Optometrist, Chiropractor, Psychologist (Ph.D.), Masters in Social Work, MDS Nurse (Skilled Nursing Facility), Recreational, Physical or Occupational Therapist.

SUBMIT PARTS 1 AND 2 OF YOUR COMPLETED APPLICATION

Return the original completed application to Great Falls Transit. Applications can be mailed to PO Box 2353, Great Falls, MT 59403, or dropped off at 3905 North Star Boulevard, Great Falls, MT

An application must include the following to be considered complete:

- Original signatures of the applicant and medical provider, photo copied of faxed applications will not be accepted.
- Parts 1 (Eligibility Application) and 2 (Professional Verification) must be returned together.
- A working telephone number is required in order to complete the application process.
- Your application will not be considered complete until all requested information has been provided to Great Falls Transit.

Incomplete applications will delay the processing of your application. Please make sure all sections are completed.

Great Falls Transit may need specific information about the effects of your disability. You may be asked to provide additional information and/or participate in a physical or cognitive functional assessment.

Great Falls Transit will process your application and notify you within 21 days after your completed application has been received in our office.

If you have any questions, or need assistance in completing this application please call 406-727-0382 (TTY 406-727-0382).

PART 1 – ELIGIBILITY APPLICATION

Section 1. APPLICANT INFORMATION

Is this a new application, or a renewal? NEW RENEWAL

APPLICANT INFORMATION

Last Name _____ First _____ Initial _____
Address _____ Apt# _____
City _____ State _____ Zip Code _____
Home Phone _____ Mobile Phone _____
TTY Phone: _____ (Text Telephone for the hearing impaired)
Date of Birth (Month/Day/Year) _____ Male Female
Language Ability- English _____ Other (Specify) _____

LEGAL GUARDIAN INFORMATION

If a person other than the applicant filled out this application, please complete the following

Last Name _____ First _____ Initial _____
Address _____ Apt# _____
City _____ State _____ Zip Code _____
Home Phone _____ Mobile Phone _____
Relationship to Applicant (family member, case worker, etc.) _____

EMERGENCY CONTACT

In case of an emergency, provide the following information so we know who to contact.

Emergency Contact _____ Relationship _____
Phone number _____ Mobile number _____

Section 2. ADA ELIGIBILITY INFORMATION

Is your need for Paratransit service temporary or long term?

Temporary Long Term *(recertification is required every two years for long term eligibility)*

What is your primary form of transportation?

- Walking Driving Riding the bus Ride with someone
- Bicycle Taxi Paratransit service Other, specify: _____

Can you ride the regular bus without the aid of another person? Yes No Sometimes

What are your limiting disabilities? _____

Does your disability prevent you from riding the city bus service?

- Yes No Sometimes

Does your limiting condition change from time to time because of medical treatments, medications, or for other reasons?

Yes No, If yes, how does it change? _____

Do weather conditions and/or terrain conditions (heat, cold, rain, snow or ice, hills, uneven surfaces, curbs) prevent you from using the city bus service without the aid of another person?

Yes No, If yes, please explain? _____

How far are you able to walk or travel using a mobility device without the aid of another person?

- Less than 1 block 2 blocks 3 blocks 4 blocks or more
- Not able to travel any distance without the aid of another person

How far is your residence from the nearest bus stop? *(For bus stop information please call 406-727-0382)*

- Less than 1 block 1 block 2 blocks 3 blocks
- 1/4 mile 1/2 mile 3/4 mile 1 mile or more

How many stairs are you able to go up or down without the aid of another person?

2 or more stairs 1 stair none

Do you ride or have you ever ridden the city bus without the aid of another person?

Yes No, If yes, when? _____ Where? _____

How often? _____ Why did you stop riding? _____

Are you able to find your way to and from the bus stop without the aid of another person?

Yes No

I get confused at times. Yes No Sometimes

I need someone to help me get to and from the bus stop. Yes No Sometimes

I need help to transfer from one bus to another. Yes No Sometimes

Great Falls Transit provides free training to help learn to ride the fixed route buses. Would you be interested in learning how to use the city bus service? Yes No, please explain _____

Can you, with a mobility aid if needed:

Move yourself from your threshold/door to the street curb? Yes No

Wait at the street or curb for a ride? Yes No

Wait at the front door/lobby for your ride? Yes No

(Please Note: Great Falls Transit District drivers are not allowed to cross the outer threshold or door of any residence, facility or business)

Explain how your disability prevents you from the following:

Please provide a complete and specific answer. Attach additional page(s) if needed.

- a. Getting on or off a ramp or lift equipped fixed-route bus; and/or
- b. Getting to or from a bus stop; and/or
- c. Successfully completing a bus trip

Section 2. FUNCTIONAL ABILITIES

A. Please answer the following questions:

Are you able to ask for, understand, and follow directions?	<input type="checkbox"/> Always	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes
Are you able to cope with unexpected problems or a change in your routine?	<input type="checkbox"/> Always	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes
Are you able to recognize landmarks?	<input type="checkbox"/> Always	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes
Are you able to tell time?	<input type="checkbox"/> Always	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes
Are you able to cross a busy street at a crosswalk?	<input type="checkbox"/> Always	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes
Are you able to use a telephone/cell phone to receive calls?	<input type="checkbox"/> Always	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes
Are you able to transfer from one bus to another?	<input type="checkbox"/> Always	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes
Are you able to see well enough to get to a bus stop?	<input type="checkbox"/> Always	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes
Are you able to find your way to and from the regular bus stop without the aid of another person?	<input type="checkbox"/> Always	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes

Please explain any boxes checked sometimes. _____

B. Do you use a service animal to assist you? Yes No Sometimes

If yes, what type of service animal _____

C. Do you travel with portable oxygen? Yes No Sometimes

D. If you are eligible for Paratransit services, will you need assistance to and from your door to the van? Yes No Sometimes, specify: _____

E. Will you need to bring a Personal Care Attendant (PCA) to assist you during your trip? Yes No Sometimes, specify: _____

Section 3. MOBILITY AIDS

A. When traveling in the community do you use mobility aids or assistive equipment?

Yes No Sometimes, if yes, what mobility aids or assistive equipment do you use?

White cane Cane/crutches Walker Braces Motorized wheelchair

Scooter Manual wheelchair Other (please specify) _____

Please explain when/ how you use mobility aids or assistive equipment _____

B. If you use a wheelchair or a scooter, is it more than 30 inches wide, 48 inches long, or is the combined weight of chair and occupant over 600 pounds?

Yes No, If yes, specify dimensions and weight _____

(Please Note: Larger mobility devices and devices that exceed 600 pounds when occupied may exceed equipment transportation capacity.)

C. If you use a manual wheelchair are you able to get around without the aid of another person?

Yes No If yes, how far? _____

D. Is there any additional information regarding your condition which has not been addressed? If so please explain: _____

Section 4. Application Signature

By signing below, you authorize the release of verification information and any other information relevant for the purpose of evaluating your eligibility for the Paratransit Service to Great Falls Transit or its representatives.

Please be advised Great Falls Transit will use your statements to determine your eligibility for transit benefits as provided by law. The statements contained herein are material to GFT's determination and GFT may act in reliance thereon.

I understand that falsification of information could result in the denial of ADA Paratransit services as well as a penalty under state (MT 80-4-428) and federal law.

Great Falls Transit may share your eligibility determination with other transit providers, as requested by you, to facilitate travel in other transit districts.

I hereby certify under the penalty of perjury under the laws of the state of Montana that the information provided on this application is true and correct.

Signature

Date

Signature by: (please check one) Applicant Designated Power of Attorney Legal Guardian

This form must be signed by the Applicant or by the individual who has designated Power of Attorney, or is a legal Guardian for the Applicant. If the Applicant is under 18 years of age a parent or guardian must sign this form.

PART 2 – PROFESSIONAL VERIFICATION

Information Release

Medical Information / HIPPA Authorization

I, _____ authorize the healthcare provider (listed below), and their office completing this application to release to Great Falls Transit District any protected health information about my disability in order to verify my eligibility for Paratransit service. 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 this application unless revoked in writing.

Applicant Signature

Date

Applicant Name (Printed)

Date

LIST OF QUALIFIED MEDICAL PROFESSIONALS:

- Medical Doctor
- Physicians Assistant
- Nurse Practitioner
- Optometrist
- Chiropractor
- Psychologist (Ph.D.)
- Masters in Social Work
- MDS Nurse (Skilled Nursing Facility)
- Recreational, Physical or Occupational Therapist

Your Health Care Provider

Health Care Provider		
Provider	Profession	
Address	Phone	Fax



Great Falls Transit District
PO Box 2353
Great Falls MT 59403
(406)727-0382

Dear Healthcare Professional:

The patient listed on the accompanying release form is applying for Great Falls Transit District Paratransit Service. The information you provide in answering the questions on the enclosed questionnaire will aid Great Falls Transit District in making a Paratransit eligibility determination. Please keep in mind this document is time sensitive. Because demand for this service is high, qualification criteria are stringent. For the benefit of the applicant, please answer all of the questions completely and accurately. Please return completed questionnaires to the applicant so the applicant can return the completed packet to Great Falls Transit District.

In accordance with Americans with Disabilities Act (ADA) guidelines, Paratransit service is available only for persons who have disabilities that prevent them from traveling on Fixed Route Buses. The individual could be prevented by inability to independently get to and from a bus stop, on or off a bus, or to successfully navigate to a destination.

Please keep in mind ADA Paratransit eligibility is not based on age, a medical condition, the inability to drive, or the use of a particular mobility aid. The severity of a disability does not confer eligibility. Comfort and convenience are not factors. ADA Paratransit eligibility is based on the EFFECT a disability has on the client's ability to use the regular Great Falls Transit District lift and ramp equipped Fixed Route Bus system.

All information provided will remain confidential. If you have any questions, please call (406)727-0382.

Thank you for your time and assistance,

Great Falls Transit District Paratransit Service

Section 1. General Disability Questions

Please describe the diagnosed disability or disabilities you are currently treating this individual for:

Check all that apply

Is the patient's disability:

Permanent Stable Progressive Temporary - How long? Months _____ Years _____

Does your client's disability:

- Affect mobility Affect judgement Require the use of a mobility aid
- Require them to have assistance when traveling outside their residence
(checking this box means the client cannot travel safely without a PCA)

Can your client:

- Walk two blocks (600 feet) with their mobility aid? Yes No
- Climb three standard steps without assistance? Yes No
- Stand without support for 15 minutes? Yes No
- Walk or stand without debilitating pain or discomfort? Yes No
- Board or deboard a lift or ramp equipped bus? Yes No
- Recognize correct stops or landmarks to complete a trip? Yes No
- Hear and understand verbal information? Yes No
- Read and understand informational signs? Yes No
- Communicate information about themselves Yes No

Section 2. Disability Specific Questions

Does the applicant experience seizures? Yes No

Is the applicant's judgement impaired? Yes No

Does this condition affect the applicant's ability to move independently outside their residence or a supervised environment? Yes No

Does the applicant experience hallucinations, delusions, or disassociation? Yes No

Does this prevent the applicant from being oriented to person, place & time? Yes No

Please describe any triggers that may cause psychological disorders to manifest: _____

Please describe the functional limitations caused by this impairment: _____

Section 3. Mobility and Safety Question

Does the applicant have a visual impairment that affects their ability to move about in the environment? Yes No, if yes, please explain: _____

Has the applicant received any orientation & mobility training? Yes No, if yes, please explain: _____

Please list any side effects of medication the applicant experiences that could affect transporting them safely? Yes No, if yes, please explain: _____

Would you like to add any additional comments on the functional ability of the applicant?

Section 4. Provider Affirmation

Provider Information		
Address	Phone	Fax
City	State	Zip Code
Provider UPIN # or Tax ID	Employer/Agency	

Provider Signature and Affirmation

I am a licensed medical provider or qualified service provider and certify that the above-mentioned individual has the disability and limitations indicated above.

Provider Signature

Date

Provider Name (printed)