

## **ISLAND TRANSIT ADA PARATRANSIT APPLICATION FOR CERTIFICATION OF ELIGIBILITY**

Please complete this application as thoroughly as possible and to the best of your ability. If there are questions you do not understand, call Island Transit at (409) 797-3909 for assistance before returning this form. In order to be considered complete, every question on the application must be answered.

Each applicant is responsible for including verification for ADA service from their healthcare professional on letterhead.

### **INSTRUCTIONS FOR APPLYING TO ISLAND TRANSIT PARATRANSIT**

SERVICES ALL INFORMATION IS CONFIDENTIAL. To apply you must:

1. Complete all sections and questions of this application.
2. Have your physician or certified healthcare professional complete and sign the Application for Certification of Eligibility form.
3. Have your physician or certified healthcare professional submit an additional signature on his/her letterhead verifying completion of this application form to help us prevent fraudulent application.
4. Return the completed application with the physician or certified healthcare professional verification on letterhead to the address listed below.

***Return completed applications to:  
Island Transit  
3115 Market Street  
Galveston, Texas 77550***

***If you have any questions, please call Island Transit at (409) 797-3909  
or by fax at (409) 877-1558.***

Island Transit will notify you within 21 days after receiving a complete application. Island Transit reserves the right to require additional information. Final decisions will be made by Island Transit staff. If the application is denied, the applicant has the right to appeal in writing to the above address.

### BASIC INFORMATION

|                      |      |  |    |  |     |              |
|----------------------|------|--|----|--|-----|--------------|
| <b>Name</b>          |      |  |    |  |     |              |
| <b>Date of Birth</b> |      |  |    |  |     |              |
| <b>Phone Number</b>  | Work |  |    |  |     |              |
|                      | Home |  |    |  |     |              |
| <b>Address</b>       |      |  |    |  |     | <b>APT #</b> |
|                      | City |  | ST |  | ZIP |              |

### EMERGENCY CONTACT INFORMATION

|                     |      |  |    |  |     |             |
|---------------------|------|--|----|--|-----|-------------|
| <b>Name</b>         |      |  |    |  |     |             |
| <b>Relationship</b> |      |  |    |  |     |             |
| <b>Phone Number</b> | Work |  |    |  |     |             |
|                     | Home |  |    |  |     |             |
| <b>Address</b>      |      |  |    |  |     | <b>APT#</b> |
|                     | City |  | ST |  | ZIP |             |

### INFORMATION ABOUT YOUR CURRENT ISLAND TRANSIT USE

|  |            |           |
|--|------------|-----------|
| <b>Do you currently use Island Transit fixed-route bus service at all?</b> | <b>Yes</b> | <b>No</b> |
| <b>When was the last time you used Island Transit fixed-route service?</b> |            |           |
| <b>Where is the closest bus stop to your residence?</b>                    |            |           |

## WEATHER AND ENVIRONMENT CONSIDERATIONS

The following questions deal with how environmental factors impact your ability to use fixed-route or paratransit services.

|  |        |           |       |            |
|--|--------|-----------|-------|------------|
| Does the weather affect your ability to use the fixed- route service?                | Always | Sometimes | Never | Don't Know |
| Explain  |        |           |       |            |
|  |        |           |       |            |
| How many steps are there at the entrance of your home?                               |        |           |       |            |
| Can you get to the Paratransit vehicle without the assistance of another individual? |        |           | Yes   | No         |
| Please describe the terrain near your residence.                                     |        |           |       |            |
|  |        |           |       |            |
| Are there sidewalks in your neighborhood?  |        |           | Yes   | No         |

## ADDITIONAL INFORMATION

Use this space to tell us anything else you would like us to know about your travel challenges and your ability to use fixed-route service.

|  |
|--|
|  |
|  |
|  |
|  |

|   |      |  |    |  |     |
|---|------|--|----|--|-----|
| Did you require any assistance to complete this form?                               |      |  |    |  |     |
| If yes, how did he/she assist you?  |      |  |    |  |     |
|   |      |  |    |  |     |
| I hereby certify that all information provided is correct.                          |      |  |    |  |     |
| Signature of Applicant  |      |  |    |  |     |
| Date  |      |  |    |  |     |
| If you are filling out this application for another person, fill-out the following: |      |  |    |  |     |
| Your Name   |      |  |    |  |     |
| Relationship  |      |  |    |  |     |
| Phone Number  |      |  |    |  |     |
| Address   |      |  |    |  |     |
|   | City |  | ST |  | ZIP |

**PART II — Please answer all of the following questions regarding YOUR mobility.**

1. Are you able to board and disembark without assistance from an Island Transit Bus *without* a wheelchair lift?

Yes \_\_\_\_\_ No \_\_\_\_\_ If no, please explain \_\_\_\_\_

2. Are you able to board and disembark without assistance from an Island Transit bus *with* a wheelchair lift?

Yes \_\_\_\_\_ No \_\_\_\_\_ If no, please explain \_\_\_\_\_

3. Are you able to travel to the nearest bus stop?

Yes \_\_\_\_\_ No \_\_\_\_\_ If no, please explain \_\_\_\_\_

Location \_\_\_\_\_ How Far? \_\_\_\_\_

4. Do you currently use Island Transit services?

a. Fixed Route Services? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, what route number(s)? \_\_\_\_\_

b. Island Transit ADA Paratransit Services? Yes \_\_\_\_\_ No \_\_\_\_\_

5. Are you able to handle money and transfers?

Yes \_\_\_\_\_ No \_\_\_\_\_ If no, please explain \_\_\_\_\_

6. Are you able to use railings and handles?

Yes \_\_\_\_\_ No \_\_\_\_\_ If no, please explain \_\_\_\_\_

7. Are you able to keep balance while seated on a moving bus?

Yes \_\_\_\_\_ No \_\_\_\_\_

8. Are you able to understand bus schedules?

Understand and follow directions? Yes \_\_\_\_\_ No \_\_\_\_\_

Process information to ride Island Transit? Yes \_\_\_\_\_ No \_\_\_\_\_

9. If you can use a lift-equipped bus, are you presently unable to ride because:

\_\_\_\_\_ The lift cannot be operated at bus stops where you need to board?

\_\_\_\_\_ Your wheelchair cannot be accommodated on a transit vehicle?

\_\_\_\_\_ Other reasons. Please explain: \_\_\_\_\_

10. Are you prevented from traveling to or from a bus stop boarding location for one or more of the following reasons?

\_\_\_\_\_ Extreme sensitivity to climatic conditions

\_\_\_\_\_ Allergic/environmental sensitivities

\_\_\_\_\_ Hyper-fatigue, frailty

\_\_\_\_\_ Night blindness

\_\_\_\_\_ Inability to cross busy intersections

\_\_\_\_\_ Inability to climb three 10-inch steps

\_\_\_\_\_ Bus stop too far away

Please explain: \_\_\_\_\_

11. Are you able to perform the following functions without supervision?

a. Find your way between familiar locations?

Yes \_\_\_\_\_ No \_\_\_\_\_ Yes, with training \_\_\_\_\_

b. Signal the bus driver to get off at a familiar stop and get off the bus there?

Yes \_\_\_\_\_ No \_\_\_\_\_ Yes, with training \_\_\_\_\_

12. Are you able to perform the following functions without the assistance of another person?  
(Y/N)

\_\_\_\_\_ Travel 300 feet (the length of a city block)

\_\_\_\_\_ Travel 900 feet (the length of three city blocks)

\_\_\_\_\_ What is the maximum distance you can travel to get to a bus stop? \_\_\_\_\_

13. Is your ability to get from place to place affected by:

\_\_\_\_\_ Terrain

\_\_\_\_\_ Rain, snow, ice

\_\_\_\_\_ Extreme temperatures of heat or very cold, windy weather

14. Are you able to wait outdoors for 15 minutes?

Yes \_\_\_\_\_ No \_\_\_\_\_ Sometimes \_\_\_\_\_

If no, please explain: \_\_\_\_\_

15. Do you have trouble standing for more than 15 minutes?

Yes \_\_\_\_\_ No \_\_\_\_\_ Sometimes \_\_\_\_\_

If no, please explain \_\_\_\_\_

16. Does your disability allow you to use the bus when you are feeling well?

Yes \_\_\_\_\_ No \_\_\_\_\_

17. Does your disability allow you to use the bus when you are *not* feeling well?

Yes \_\_\_\_\_ No \_\_\_\_\_

18. How would you describe the terrain where you live? (Very steep incline or hill, long gradual slope or flat) \_\_\_\_\_

19. Are you able to cross the street or a busy intersection by yourself?

Yes \_\_\_\_\_ No \_\_\_\_\_

20. Have you ever received mobility training for routes or destinations?

Yes \_\_\_\_\_ No \_\_\_\_\_

21. If travel training were available, would you be interested in participating?

Yes \_\_\_\_\_ No \_\_\_\_\_

22. List three of your most frequent destinations and how you get there?

| Frequency | Destination or Street Address of Travel | How do you get there now? |
|-----------|---|---------------------------|
| _____     | _____                                   | _____                     |
| _____     | _____                                   | _____                     |
| _____     | _____                                   | _____                     |

23. Are there places you would like to go that you *cannot* get to now?

| Frequency | Destination or Street Address of Travel | How do you get there now? |
|-----------|---|---------------------------|
| _____     | _____                                   | _____                     |
| _____     | _____                                   | _____                     |
| _____     | _____                                   | _____                     |

24. How did you find out about the Island Transit ADA Paratransit services? (telephone call, website, medical provider, other)

\_\_\_\_\_  
\_\_\_\_\_





## IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)  
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

**Definitions** - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

**Health Information to be Released** - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

**Note on Release of Health Records** - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

**Authorizations for Sale or Marketing Purposes** - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code § 181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

**Limitations of this form** - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii)); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii)); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

**Charges** - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

**Right to Receive Copy** - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

**Information Collected for Federal Government Grant Applications**

(1) The information requested below is voluntary, (2) the race and ethnic information will not affect an applicant's eligibility or level of benefits, and (3) the reason for the collection of the information is to assure that program benefits are distributed without regard to race, color, or national origin. The individual may self-identify his or her racial/ethnic status on the application. Visual observation by a program representative is used to collect the data when the individual does not self-identify. Applicant may decline to answer the following question which is asked for the purpose of federal grant applications and will not affect the applicant's eligibility for the Island Transit ADA paratransit service. Please check the designation that most accurately reflects your race/ethnicity. You may check more than one or indicate that you do not wish to provide the information:

- |  |                                   |   |
|--|-----------------------------------|---|
| <input type="checkbox"/> American Indian or Alaskan Native   | <input type="checkbox"/> White    | <input type="checkbox"/> I do not wish to provide this information. |
| <input type="checkbox"/> Native Hawaiian or Pacific Islander | <input type="checkbox"/> Asian    |   |
| <input type="checkbox"/> Black or African American           | <input type="checkbox"/> Hispanic |   |

|                            |  |                      |  |
|----------------------------|--|----------------------|--|
| <b>FOR OFFICE USE ONLY</b> |  |                      |  |
| <b>Date Received</b>       |  | <b>Date Approved</b> |  |

**Expiration Date:** \_\_\_\_\_

**Office Use Only**

Screening Committee Review:

Reviewed By \_\_\_\_\_ Date: \_\_\_\_\_ Decision: \_\_\_\_\_

Reviewed By \_\_\_\_\_ Date: \_\_\_\_\_ Decision: \_\_\_\_\_

Reviewed By \_\_\_\_\_ Date: \_\_\_\_\_ Decision: \_\_\_\_\_

Comments: \_\_\_\_\_

**Dear Health Care Provider:**

The Americans with Disabilities Act (ADA) and its implementing federal regulations established categories of persons who are eligible to receive paratransit services complementary to fixed-route bus services. The three categories of persons with rights to complementary paratransit are:

1. Persons who, because of their disability, cannot independently board, ride and/or disembark from an accessible vehicle.
2. Persons who, because of their disability, cannot use vehicles without lifts or other accommodations.
3. Persons who, because of their disability, cannot get to or from a boarding or disembarking location.

**PLEASE NOTE:** Any individual is to be certified as ADA paratransit eligible if there is any part of the transit system that cannot be used or navigated by that individual because of a disability. Persons are not to be qualified or disqualified on the basis of a specific diagnosis or disability. The information requested from you on the following pages will allow Island Transit to obtain the information necessary to establish eligibility of the applicant. Thank you for your assistance.

**PART V — To be completed by an appropriate Health Care Provider (Please Print or Type)**

Please Check One:  Physician  Licensed Health Care Provider

Licensed Rehab/Social Worker

Applicant's Name \_\_\_\_\_  
(Last, First, Middle Initial)

Medical diagnosis of condition causing disability: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is this condition permanent?

Yes  No  If not, expected duration? \_\_\_\_\_

Does the disability prevent the applicant from utilizing the fixed route services (regular bus service)? If yes, please describe in detail: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PART V — To be completed by an appropriate Health Care Provider**

The following information will be used to ensure that an appropriate vehicle is sent to provide transportation and that Island Transit can make an accurate analysis of the applicant's trip request.

Does the applicant use any of the following mobility aids? (Check all that apply)

- Cane  Power Chair  Communication Board  White Cane  
 Large Power Chair  Service Animal  Walker  Power Scooter  
 Portable Oxygen Supply  Crutches  Manual Chair  Leg Braces  
 Personal Care Attendant  Picture/Alphabet Board  Other: \_\_\_\_\_

Please indicate below if the applicant can be left alone:

- Applicant can be left alone  Applicant can't be left alone

Can the applicant walk or wheel 900 feet (3 blocks) without the assistance of another person?

Yes  No

1. Can the applicant climb three 10-inch steps with assistance?

Yes  No

2. Can the applicant wait outside without support for 15 minutes?

Yes  No

3. Is the patient on dialysis?

Yes  No

4. Does the applicant have a hearing impairment?

Yes  No

5. Is the applicant able to give addresses and phone numbers upon request?

Yes  No

6. Is the applicant able to recognize a destination or landmark?

Yes  No

7. Is the applicant able to deal with unexpected situations or unexpected changes in routine?

Yes \_\_\_\_\_ No \_\_\_\_\_

8. Is the applicant able to ask for, understand, and follow directions?

Yes \_\_\_\_\_ No \_\_\_\_\_

9. Is the applicant able to safely and effectively travel alone through crowded and/or complex facilities?

Yes \_\_\_\_\_ No \_\_\_\_\_

**\*\* If the applicant has a visual impairment:**

Visual acuity with best correction: Right Eye \_\_\_\_\_ Left eye \_\_\_\_\_ both eyes \_\_\_\_\_

Visual fields: Right Eye \_\_\_\_\_ Left eye \_\_\_\_\_ both eyes \_\_\_\_\_

Please describe any other disability or effect that prevents the applicant from using the regular bus service: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**PART V**

Based upon my professional knowledge of the applicant, I certify that the preceding information is true and correct.

Name of Health Care Provider (Please Print) / Office Phone Number

\_\_\_\_\_

Office Street Address (City, State, Zip Code)

\_\_\_\_\_

State License Number (Complete If Applicable – Must Be Current)

\_\_\_\_\_

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