



**Northern Arizona Intergovernmental Public Transportation Authority**

3773 N. Kaspar Drive • Flagstaff, AZ 86004 • 928-679-8900 • FAX 928-779-6868 • [www.naipta.az.gov](http://www.naipta.az.gov)

Good Afternoon,

Thank you for your interest regarding our Paratransit transportation program. Please be sure to read and complete the application thoroughly. You may be eligible for ADA Paratransit Certification, which would give you greater access to our services.

If you need assistance completing the application or have any questions please contact me at (928) 679-8911. Once all sections of the application have been completed, please return to my attention at your earliest convenience. I look forward to hearing from you soon.

Sincerely,

*Rachelle Marble*

Rachelle Marble  
Mobility Specialist  
Mountain Lift  
NAIPTA

Return application and professional verification to:

**NAIPTA- Mountain Lift  
Rachelle Marble  
3773 N Kaspar Dr.  
Flagstaff, AZ 86004  
Or  
Fax to: 928-779-6868**



*Getting you where you want to go*



## PLEASE READ THIS BEFORE FILLING OUT THE APPLICATION

### ADA Paratransit Service Eligibility Process

#### WHY DO WE HAVE PARATRANSIT?

The Americans with Disabilities Act of 1990 (ADA), a civil rights bill, was designed to remove the barriers which prevent people with disabilities from fully participating in American society. In public transportation, the ADA clearly states that regular bus service should be the primary means of public transportation for everyone, including people with disabilities.

Under the ADA, public transit agencies are required to provide origin to destination, demand-response Paratransit service which parallels the fixed route service in terms of days, times and service area. The service is only for those people with disabilities who do not have the **functional** ability to ride fixed-route buses, either permanently or under certain conditions. The fixed-route bus system is fully accessible, with wheelchair accessible buses and major transfer facilities.

In addition, other accommodations such as bus stop and route announcements and easy-to-read signs make using the fixed-route buses possible for many people with disabilities. People who can use fixed-route buses are expected to do so whenever they are able. The unavailability of fixed-route service does not constitute eligibility for a person who could otherwise take the same trip on buses, if service were available.

Travel Training instruction is available to those who need help in learning how to use the fixed-route buses.

#### WHO IS ELIGIBLE TO USE PARATRANSIT?

Under the ADA, disability alone does not qualify a person to ride Paratransit. A person must be functionally unable to use the fixed-route service. Paratransit service is provided to the following three general groups of people with disabilities:

1. People who have specific impairment-related conditions which make it impossible — not just difficult — to travel to or from a bus stop.
2. People who need an ADA accessible bus, but it is not available on the fixed-route when they need to travel. **All NAIPTA fixed-route buses are ADA accessible.**
3. People who are unable to board, ride, or disembark from the fixed-route buses even if they can get to a bus stop and the bus is ADA accessible.



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Those people who are certified eligible are classified as having unconditional, temporary, or conditional eligibility for ADA Paratransit Service as follows:

**Unconditional** status is assigned to people who are determined unable to ever independently use fixed-route buses, even with training.

**Temporary** status is assigned to people who are determined capable of using accessible buses but cannot do so at present, either because of a temporary disability or other temporary changes to the bus route, stops, or other conditions.

**Conditional** status is assigned to people who can use fixed-route buses some of the time, but would, under certain circumstances and for certain trips, be prevented from independently using fixed-route buses. Examples of conditional eligibility include people with extreme fatigue after treatments such as dialysis, a bus stop which requires a traveler who is blind to maneuver a dangerous pedestrian area such as a large, open parking lot with no reference points, or a fixed-route bus route that is not yet accessible.

## EVALUATION PROCEDURE

All applicants seeking eligibility for ADA Paratransit Service must complete the eligibility determination process. This includes a medical verification of disability, the applicant's own assessment of his/her ability to use fixed-route buses, and an in-person evaluation interview. Information provided by a social service agency or other professional regarding the applicant's ability to use the fixed-route bus may also be considered.

The purpose of the in-person evaluation interview is to determine when and under what circumstances the applicant can use fixed-route buses and when Paratransit Service is required. The interview consists of a series of questions designed to evaluate the functional abilities, limitations, and individual needs of each applicant. Variables in the environment, as well as the applicant's ability to perform the tasks required to use the bus, are also considered.

Transportation assistance is provided as necessary to and from the evaluation appointment.

All requested information must be provided and the application process completed before an eligibility determination can be rendered.

## APPEALS

Information regarding the appeals process is available from the Paratransit Program Manager. Applicants who are determined not eligible, or who do not agree with the conditions established for their use of ADA Paratransit Service, may request a review of their determination by the Appeals Committee.

We are always happy to hear from you. Questions? Need Assistance?  
Please call: (928) 679-8911

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## THIS WORKSHEET IS FOR YOUR OWN USE

### ADA Eligibility - Is Paratransit right for you?

Your Name: \_\_\_\_\_

This worksheet will help you understand ADA eligibility and determine if Paratransit is the appropriate service for you. The Americans with Disabilities Act states that ADA eligibility is given to people whose disabilities prevent usage of regular, accessible fixed-route transit services: **An individual's disabilities must be so significant that the individual is not able to use fixed-route transit service.**

Read the four questions on the left side of the worksheet and then check your answers on the right side. Your answers will help determine if Paratransit might be appropriate for you.

Questions	Check your answers below		
	Yes	Sometimes	Never
1. Are you able to get to and from the bus stop closest to where you live?			
2. With help from the bus driver, are you able to get on and off a bus that has a <b>lift or a ramp</b> ?			
3. With help from the bus driver who announces major bus stops and transfer points, are you able to figure out the right bus stop to get off?			
4. If your trip on the bus involves transferring to another bus, are you able to make the transfer?			

#### Look at your answers:

If you checked "Yes" to all 4 questions, you probably would not be determined ADA eligible.

If you checked "Sometimes" to one or more questions, you might be determined ADA eligible for certain trips under certain conditions.

If you answered "Never" to one or more of the questions, you might be determined ADA eligible.

A completed application and in-person interview at our NAIPTA office is necessary to formally determine ADA eligibility.



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Providing Courteous and Responsive Transportation

**PARATRANSIT SERVICE AND  
ADA ELIGIBILITY APPLICATION  
AND INFORMATION**



# ADA PARATRANSIT APPLICATION FORM

Please complete this application to the best of your ability and as thoroughly as possible. If you have difficulty answering any questions on the application, or if you need assistance completing this form, please contact the Mobility Specialist at (928) 679-8911. For the application to be considered complete, **every** question on the application must be answered. We cannot begin processing the application until it is complete. If a question does not apply to you, please write 'Not Applicable' or 'NA'.

The purpose of this application is to provide an opportunity for you to describe how your disability prevents you from riding the fixed-route system. This includes any environmental and/or physical barriers that prevent you from riding the fixed-route buses. The unavailability of fixed-route service does not constitute eligibility for a person who could otherwise take the same trip on buses, if service were available.

The more complete and accurate the information you provide, the better NAIPTA/Mountain Lift will understand your abilities and travel challenges. Information contained in this application will be kept confidential and will only be shared with the professionals involved in the evaluation of your eligibility for NAIPTA/Mountain Lift, or others if disclosure is required by law.

**There are three sections to this application. Parts A and B are to be filled out by the applicant or by someone on the applicant's behalf. Part C is to be filled out by a professional familiar with the applicant's functional abilities. The application will not be accepted or considered complete until all three parts are completed in full and submitted to NAIPTA.**

**If you have questions regarding ADA Paratransit Eligibility or these forms, contact the  
Mobility Specialist at NAIPTA/Mountain Lift at (928) 679-8911.**

**Please return the completed form to:  
Mobility Specialist  
NAIPTA - Mountain Lift  
3773 N. Kaspar Drive, Flagstaff, AZ 86004  
Or fax to: 928-779-6868**

## PART A - APPLICANT DATA

**PLEASE PRINT**

**DATE** \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contact Phone Number(s) \_\_\_\_\_

Email Address \_\_\_\_\_

Is the mailing address the same as your physical address? \_\_\_\_\_ If not please provide mailing address.

Should correspondence be sent to any individual other than applicant, such as a case manager, social worker or family member? If so, please provide the information below:

Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

Contact Phone Number (s) \_\_\_\_\_

Email Address \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

Will you need future correspondence in an alternative format? \_\_\_\_\_

If so, please describe. \_\_\_\_\_

### **EMERGENCY CONTACT INFORMATION**

Please provide information for the person we should contact on your behalf in case of emergency.

Name \_\_\_\_\_

Contact Phone Number(s) \_\_\_\_\_

Email Address \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

**To be completed by any person assisting the applicant with the completion of this application:**

Name \_\_\_\_\_

Contact Phone Number(s) \_\_\_\_\_

Email Address \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

## INFORMATION ABOUT YOUR DISABILITY AND MOBILITY EQUIPMENT

Describe the disability or health condition that prevents you from using the fixed-route system.

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Is your disability or health condition considered permanent? \_\_\_\_\_ Yes \_\_\_\_\_ No

If no, what is the expected duration? \_\_\_\_\_

Does your disability or health condition change from day to day? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_

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Does your disability require you to travel with a personal care attendant? \_\_\_\_\_ Yes \_\_\_\_\_ No

**A personal care attendant or PCA is a person traveling as an aide, designated or employed by a person with disabilities to help that person meet his or her personal needs and/or facilitate travel.**

What type of mobility aid and/or adaptive equipment do you use?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> NA                   |   |   |
| <input type="checkbox"/> Scooter              | <input type="checkbox"/> Power Wheelchair | <input type="checkbox"/> Manual Wheelchair        |
| <input type="checkbox"/> Wheeled Walker       | <input type="checkbox"/> Support Cane     | <input type="checkbox"/> Cane                     |
| <input type="checkbox"/> Crutches             | <input type="checkbox"/> Walker           | <input type="checkbox"/> Prostheses:              |
| <input type="checkbox"/> Leg Braces           | <input type="checkbox"/> Portable Oxygen  | <input type="checkbox"/> White Cane               |
| <input type="checkbox"/> Monocular            | <input type="checkbox"/> Telescope        | <input type="checkbox"/> Electronic Travel Device |
| <input type="checkbox"/> Service Animal       | <input type="checkbox"/> Hearing Aid      | <input type="checkbox"/> ASL Interpreter          |
| <input type="checkbox"/> Voice Box            | <input type="checkbox"/> Picture Board    | <input type="checkbox"/> Alphabet Board           |
| <input type="checkbox"/> Language Interpreter |   | <input type="checkbox"/> Other:                   |

### Required of all wheelchair and scooter users:

Is your device more than 30 inches wide? \_\_\_\_\_ Yes \_\_\_\_\_ No

Is your device more than 48 inches long? \_\_\_\_\_ Yes \_\_\_\_\_ No

Is the combined weight of the device and occupant greater than 600 pounds? \_\_\_\_\_ Yes \_\_\_\_\_ No



## INFORMATION REGARDING VISUAL IMPAIRMENT

Please fill out this section if you have a visual impairment. If not applicable, please write NA.

Name of Eye Disease/Condition:

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My vision is worse during these conditions:

Bright sun     Low light     Darkness

I see the same in all lighting conditions

I have no vision at all

My eye condition is:

Stable     Degenerative     Other (please explain) \_\_\_\_\_

I can easily see steps and curbs.

I can see the route numbers on the bus from the bus stop.     Yes     No     Sometimes

I can find the bus stop without assistance.     Yes     No     Sometimes

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## INFORMATION ON TRAVEL CHALLENGES

Please use this space to describe your travel challenges and your ability to use the Mountain Line fixed-route service. Please relate your comments to the specific tasks necessary to board, ride, and navigate the transit fixed-route system by describing how each condition limits your functional ability in these specific areas. Our determination is **not** based on income or the inability to drive a vehicle.

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## PART B - INFORMATION ON INDEPENDENT TRAVEL

Do you currently use fixed-route buses?  Yes  No  Sometimes

If so, do you need the assistance of another person?  Yes  No  Sometimes

If you need another person's assistance, what does that person do for you?

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If the weather is good and there are no barriers, what is the farthest you can **independently** travel outdoors on a level sidewalk, using your mobility aid if applicable?

330 ft.

1320 ft. (< 16 min)

2310 ft.

660 ft.

1650 ft.

2640 ft. (< 32 min)

990 ft.

1980ft

Not sure

I can't travel outdoors alone at all

What is it about riding a fixed-route bus that is/would be most difficult for you? (Example: The bus moves before I am seated, etc.) Please list as many things as you can think of. If you need additional space, please use a separate piece of paper:

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Have you ever gotten lost when traveling alone?  Yes  No  I don't travel alone.  
If yes, what was the outcome of the situation?

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## INFORMATION ON THE ENVIRONMENT AROUND YOUR HOME

If you currently use the fixed-route system, which routes do you use?

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What is the closest bus stop to your home? Please give the location (ex: Corner of Fourth and Route 66):

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Can you get to this stop by yourself?  Yes  No  Sometimes

If no, what prevents you from getting to this stop?

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## INFORMATION ON WEATHER-RELATED CONDITIONS

Do weather conditions affect your ability to travel independently?  Yes  No  Sometimes

If yes, what types of weather conditions make independent travel difficult?

Hot  Cold  Rain  Wind  Snow  Ice  Humidity  Other

Explain how the above weather conditions affect your independent travel: \_\_\_\_\_

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**Please read the following statements and check which best describe your ability to use the fixed-route bus system. You may select more than one.**

	I have a temporary disability which prevents me from getting to the bus stop. I will need only until I recover.
	I can use the fixed-route bus sometimes, if the conditions are right.
	I have difficulty understanding and/or remembering all the things I need to do to find my way to and from the bus.
	I have a visual disability which prevents me from getting to and from the bus stop.
	The severity of my disability changes from day to day. I can ride the fixed-route bus only when I am feeling well.
	I have a severe medical condition. My condition results in an impairment which makes it impossible for me to use the fixed-route system.
	I believe I could learn to ride the fixed-route bus, if someone would teach me.

## INFORMATION ON FUNCTIONAL ABILITIES

Please respond to the following statements regarding your ability to complete tasks related to use of the accessible fixed-route bus service. Your answers should be based on your ability to perform these tasks *independently*, using your assistive device if applicable. Read each statement carefully and check the appropriate box.

I CAN:	YES	NO	SOMETIMES
1. Use the telephone to obtain information or assistance			
2. Obtain and comprehend information such as a bus schedule and directions for path of travel			
3. Communicate my needs, ask for and understand instructions			
4. Recognize, exchange and comprehend printed information			
5. Recognize, exchange and comprehend spoken words or auditory information			
6. Understand how to tell and monitor time			
7. Understand distances traveled			
8. Safely travel along sidewalks and other pedestrian ways			
9. Recognize curbs, curb cuts, steps and other drop offs			
10. Locate and initiate safe crossings at streets or intersections with or without pedestrian crossing signs			
11. Safely and effectively travel through crowded and/or complex facilities			
12. Problem solve if an unexpected situation arises such as encountering a barrier along the path of travel or if a bus must make a detour			
13. Locate and recognize the correct bus from signage or auditory information			
14. Identify and deposit the correct fare into the fare box or scan a bus pass			
15. Recognize destinations, bus stops or landmarks			
16. Recognize when and how to signal for a stop			
17. Understand and implement strategies for personal safety when traveling			

Please respond to the following statements regarding your ability to complete tasks related to use of the accessible fixed-route bus service. Your answers should be based on your ability to perform these tasks ***independently***, using your assistive device if applicable. Read each statement carefully and check the appropriate box.

I CAN:	YES	NO	SOMETIMES
1. Travel one block on a clear, level sidewalk • If so, how long does it take?			
2. Travel three blocks on a clear, level sidewalk • If so, how long does it take?			
3. Travel up or down a gradual hill on a clear sidewalk • If so, for what distance?			
4. Navigate around obstacles along the path of travel			
5. Negotiate on broken pavement or surfaces			
6. Negotiate on uneven or grassy surfaces			
7. Negotiate on gravel surfaces			
8. Negotiate on loose dirt or sandy surfaces			
9. Negotiate on snow covered or icy surfaces			
10. Maneuver up and down a curb cut			
11. Maneuver up and down a 6" curb			
12. Wait ten minutes at a bus stop that does not have a seat or shelter			
13. Walk up and down three steps if there are handrails on both sides			
14. Climb bus steps from street level without a curb			
15. Negotiate up /down bus ramp from street level			
16. Ambulate or wheel to a seat or wheelchair securement area			
17. Ride in a seated or standing position while vehicle is in motion			

**INFORMATION ON TRAVEL/MOBILITY TRAINING**

Have you ever received training in the use of a fixed-route bus service? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, by which agency were you trained? \_\_\_\_\_

Did you successfully complete training? \_\_\_\_\_ Yes \_\_\_\_\_ No

Which routes/trips did you learn in training? \_\_\_\_\_

If no, would you like to participate in training to learn to ride the fixed-route bus? \_\_\_\_\_ Yes \_\_\_\_\_ No

**MOBILITY TRAINING HISTORY AUTHORIZATION FORM**

If you received mobility training, it may be necessary to contact the agency which provided your training. Please complete the following information release authorization for the agency that provided your mobility training.

Name of Agency \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

I hereby authorize the certifying entity to contact any agency or professional indicated to verify documentation of functional abilities and limitations.

Applicant's Signature or Mark \_\_\_\_\_ Date \_\_\_\_\_



**I certify I have been truthful in completing this form and the information I have provided is accurate. I understand the purpose of this application is to determine my eligibility to use Paratransit Services. An in-person interview and a functional assessment may be required if additional information is needed to determine my eligibility.**

Applicant's Signature or Mark:

\_\_\_\_\_

Date:

\_\_\_\_\_

Please review the application to make sure that you have answered all of the questions to the best of your ability. If there are questions that you cannot answer, please state why you cannot answer these questions.

Thank You

## **PART C - INFORMATION RELEASE FORM**

To evaluate your request for eligibility, it may be necessary to contact a professional to confirm the information you have provided or to answer additional questions. The individual completing Parts A and B of the application **cannot** be the person (s) listed below. This information release form must be completed by yourself or another on your behalf.

The following professional is familiar with my disability, health condition and functional abilities and is authorized to provide the required information to NAIPTA/Mountain Lift for certification.

**Health Care Professional:** Physician \_\_\_\_\_ Nurse \_\_\_\_\_ Physical Therapist \_\_\_\_\_ Rehabilitation Therapist \_\_\_\_\_  
Case Manager \_\_\_\_\_ Social Worker \_\_\_\_\_ Other (please explain) \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

**Health Care Professional:** Physician \_\_\_\_\_ Nurse \_\_\_\_\_ Physical Therapist \_\_\_\_\_ Rehabilitation Therapist \_\_\_\_\_  
Case Manager \_\_\_\_\_ Social Worker \_\_\_\_\_ Other (please explain) \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

I hereby authorize NAIPTA/Mountain Lift to contact the professional or agency listed above to verify documentation of functional abilities.

Applicant's Signature or Mark \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

**If you have questions regarding ADA Paratransit Eligibility or these forms, please contact the**

**Mobility Specialist at NAIPTA/Mountain Lift**

**(928) 679-8911. Our Fax number is (928) 779-6868.**

**Thank you for your cooperation.**

## **PROFESSIONAL VERIFICATION**

Please take this section of the application to a professional for verification of your disability and your functional abilities. We prefer that this section be filled out by someone who is not only familiar with your diagnosis, but who is also familiar with your mobility. We suggest taking these forms to a Case Manager, Social Worker or Health Care Professional. If you have any questions regarding which professionals will be accepted or if the professional you have chosen is charging you a fee for the completion of this paperwork, please call the Mobility Specialist at (928) 679-8911.

### **GUIDELINES FOR PROFESSIONAL VERIFICATION**

Your patient/client has requested eligibility for NAIPTA/Mountain Lift Paratransit service. Because of your professional relationship with this applicant, you are uniquely qualified to help clarify his or her functional abilities and limitations. The following are guidelines for using Paratransit. These guidelines may help you in understanding the types of information we need to determine the applicant's eligibility for Paratransit.

The basis for NAIPTA/Mountain Lift ADA eligibility is the American with Disabilities Act. Eligibility is based on:

- Functional ability to independently perform the tasks necessary for bus use including: getting to and from the bus stop, getting on the bus, riding the bus, and understanding how to navigate the system in a variety of environments. A diagnosis by itself does not qualify an individual for Paratransit Eligibility.
- Whether the individual is prevented from performing these tasks (as opposed to the task being more inconvenient or difficult)
- Whether the individual can perform these tasks all the time, only under some circumstances, or if the disability would always prevent the individual from performing these tasks. Eligibility is unique to the individual's personal functional ability and reflects the patient's ability to use the bus and under what circumstances (ex: could use the bus if it was not more than two level blocks to the bus stop, and there was no snow or ice present).

### **INFORMATION WE NEED YOU TO PROVIDE**

You may expand on, in as much detail as you can provide, how this individual's disability may impact his/her ability to travel on a bus. Please relate your comments to the specific tasks necessary to board, ride, and navigate the transit fixed-route system by describing how each condition limits his/her functional ability in these specific areas.



The following is a list of specific points which can serve as a guide for your report to NAIPTA/Mountain Lift.

Please address any of the following points that apply to the applicant on the forms provided (pages 4-8):

- **Specific diagnosis and prognosis** of each of your patient's disabling conditions. Identify which of these conditions you are currently treating.
- **Specific measurements**
  - **For the visually impaired:** visual acuity measurements and visual field readings for both eyes
  - **For the cognitively impaired:** I.Q. scores and Adaptive Behavior scores
- **Date of onset**
  - **Prognosis:** If the individual has a progressive disease or condition, or if s/he is expected to improve or recover. Provide the best estimate of the rate at which this is expected to occur, and if therapy is part of the treatment plan.
- **Mobility Impairments**
  - Can the individual walk?
  - Under what conditions can s/he walk?
  - Under what conditions can s/he not walk?
  - What mobility aids does s/he use?
  - How long has s/he been using this device?
  - How far can s/he walk/travel independently using mobility aids?
  - How do weather conditions (rain, ice, snow) affect his/her mobility?
  - How are balance and endurance affected?
- **Neurological Impairments or Head Injuries**
  - Is judgment or behavioral inhibition impaired, and to what extent?
- **Seizures**
  - What type of seizures?
  - Are they controlled by medication?
- **Emotional and/or Behavioral Problems**
  - Is judgment impaired?
  - Does s/he experience disabling anxiety, auditory or visual hallucinations, delusions, etc.?
  - General Information
  - Would the individual need the help of an assistant or companion to ride the bus?
  - How do temperature fluctuations affect his/her functioning?

## PROFESSIONAL VERIFICATION

Applicant Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Applicant Address \_\_\_\_\_

Applicant Contact Phone Number (s) \_\_\_\_\_

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In what capacity, do you know this individual? \_\_\_\_\_

How long have you known this individual? \_\_\_\_\_

What is the last date of in person contact (by you or your agency) with this individual? \_\_\_\_\_

**Primary Disability and/or Health Condition:** \_\_\_\_\_

- a. Date of onset: \_\_\_\_\_
- b. Prognosis: \_\_\_\_\_
- c. Expected duration of condition: \_\_\_\_\_
- d. Are the effects of the disability variable?  Yes  No

**Secondary Disability and/or Health Condition:** \_\_\_\_\_

- a. Date of onset: \_\_\_\_\_
- b. Prognosis: \_\_\_\_\_
- c. Expected duration of condition: \_\_\_\_\_
- d. Are the effects of the disability variable?  Yes  No

Current medications and/or medical treatments. Please attach list if additional space is required.

Name of Medication/Treatment

Date Prescribed

<u>Name of Medication/Treatment</u>	<u>Date Prescribed</u>

Medication/Treatment side effects reported by patient/client: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How does the above medication and/or medical treatments affect the individual's functional ability to travel independently within the community (ex: drowsiness, confusion, nausea, weakness, gait/balance instability, etc.)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**INFORMATION ON TRAVEL CHALLENGES**

Please use this space to elaborate how the applicant's disability affects his/her ability to travel independently. Please relate your comments to the specific tasks necessary to board, ride, and navigate the transit fixed-route system by describing how the individual's condition limits his/her functional ability in these specific areas. Our determination is **not** based on income or the inability to drive a vehicle.

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

**For the following questions, please provide information regarding the applicant's functional abilities, taking into consideration any mobility aid used if applicable.**

**What type of mobility aid and/or adaptive equipment does the individual use?**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> NA                   |   |   |
| <input type="checkbox"/> Scooter              | <input type="checkbox"/> Power Wheelchair | <input type="checkbox"/> Manual Wheelchair        |
| <input type="checkbox"/> Wheeled Walker       | <input type="checkbox"/> Support Cane     | <input type="checkbox"/> Cane                     |
| <input type="checkbox"/> Crutches             | <input type="checkbox"/> Walker           | <input type="checkbox"/> Prostheses: _____        |
| <input type="checkbox"/> Leg Braces           | <input type="checkbox"/> Portable Oxygen  | <input type="checkbox"/> White Cane               |
| <input type="checkbox"/> Monocular            | <input type="checkbox"/> Telescope        | <input type="checkbox"/> Electronic Travel Device |
| <input type="checkbox"/> Service Animal       | <input type="checkbox"/> Hearing Aid      | <input type="checkbox"/> ASL Interpreter          |
| <input type="checkbox"/> Voice Box            | <input type="checkbox"/> Picture Board    | <input type="checkbox"/> Alphabet Board           |
| <input type="checkbox"/> Language Interpreter |   | <input type="checkbox"/> Other:                   |

**Does the individual have a visual impairment?** \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please answer the following questions.

Eye Disease or condition: \_\_\_\_\_

Visual acuity measurements and visual field readings: \_\_\_\_\_

Vision is worse during these conditions: \_\_\_\_\_ Bright sun \_\_\_\_\_ Low light \_\_\_\_\_ Darkness

Individual has: \_\_\_\_\_ No vision \_\_\_\_\_ Night blindness

**Maximum distance individual can travel independently using a mobility aid if necessary?** \_\_\_\_\_ feet

\_\_\_\_\_ 330 ft. \_\_\_\_\_ 1320 ft. (< 16 min) \_\_\_\_\_ 2310 ft.

\_\_\_\_\_ 660 ft. \_\_\_\_\_ 1650 ft. \_\_\_\_\_ 2640 ft. (< 32 min)

\_\_\_\_\_ 990 ft. \_\_\_\_\_ 1980 ft.

Would the individual exhibit any signs of distress at the maximum distance? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_

**Do weather conditions affect the individual's ability to travel independently?** \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, what types of weather conditions make independent travel difficult?

\_\_\_\_\_ Hot \_\_\_\_\_ Cold \_\_\_\_\_ Rain \_\_\_\_\_ Wind \_\_\_\_\_ Snow \_\_\_\_\_ Ice \_\_\_\_\_ Humidity \_\_\_\_\_ Other

Explain how the above weather conditions affect his/her independent travel:

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

Please respond to the following statements regarding his/her ability to complete tasks related to use of the accessible fixed-route bus service. The answers should be based on his/her ability to perform these tasks ***independently***, using an assistive device if applicable. Read each statement carefully and check the appropriate box.

INDIVIDUAL CAN:	YES	NO	SOMETIMES
1. Use the telephone to obtain information or assistance			
2. Obtain and comprehend information such as a bus schedule and directions for path of travel			
3. Communicate needs, ask for and understand instructions			
4. Recognize, exchange and comprehend printed information			
5. Recognize, exchange and comprehend spoken words or auditory information			
6. Understand how to tell and monitor time			
7. Understand distances traveled			
8. Safely travel along sidewalks and other pedestrian ways			
9. Recognize curbs, curb cuts, steps and other drop offs			
10. Locate and initiate safe crossings at streets or intersections with or without pedestrian crossing signs			
11. Safely and effectively travel through crowded and/or complex facilities			
12. Problem solve if an unexpected situation arises such as encountering a barrier along the path of travel or if a bus must make a detour			
13. Locate and recognize the correct bus from signage or auditory information			
14. Identify and deposit the correct fare into the fare box or scan a bus pass			
15. Recognize destinations, bus stops or landmarks			
16. Recognize when and how to signal for a stop			
17. Understand and implement strategies for personal safety when traveling			

Please respond to the following statements regarding his/her ability to complete tasks related to use of the accessible fixed-route bus service. The answers should be based on his/her ability to perform these tasks ***independently***, using an assistive device if applicable. Read each statement carefully and check the appropriate box.

INDIVIDUAL CAN:	YES	NO	SOMETIMES
1. Travel one block on a clear, level sidewalk • If so, how long does it take?			
2. Travel three blocks on a clear, level sidewalk • If so, how long does it take?			
3. Travel up or down a gradual hill on a clear sidewalk • If so, for what distance?			
4. Navigate around obstacles along the path of travel			
5. Negotiate on broken pavement or surfaces			
6. Negotiate on uneven or grassy surfaces			
7. Negotiate on gravel surfaces			
8. Negotiate on loose dirt or sandy surfaces			
9. Negotiate on snow covered or icy surfaces			
10. Maneuver up and down a curb cut			
11. Maneuver up and down a 6" curb			
12. Wait ten minutes at a bus stop that does not have a seat or shelter			
13. Walk up and down three steps if there are handrails on both sides			
14. Climb bus steps from street level without a curb			
15. Negotiate up /down bus ramp from street level			
16. Ambulate or wheel to a seat or wheelchair securement area			
17. Ride in a seated or standing position while vehicle is in motion			

**Please check any of the following affected by the individual's disability.**

Disorientation

Monitoring time

Problem solving

Judgement

Short term memory

Communication

Long term memory

Inconsistent performance

Gait or balance

Inappropriate social behavior

Other (Please explain)

(Please explain)

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Would transit travel training be appropriate for this individual?  Yes  No

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

What training tools, if any, would be of help with fixed-route travel (ex: memory cards, written route directions, photos)? \_\_\_\_\_  
\_\_\_\_\_

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Is the goal of traveling independently on the fixed-route system within the context of treatment?  Yes  No

Please describe how having access to Paratransit will better suit this individual than using the fixed-route system. Include any additional information regarding the individual's functional ability and/or special circumstance which may assist in our determination.

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**I certify that this information is true and correct to the best of my knowledge.**

Signature \_\_\_\_\_ Title \_\_\_\_\_

\_\_\_\_\_  
Please print or type name

\_\_\_\_\_  
Please print or type title

Agency \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_  
Extension \_\_\_\_\_

\_\_\_\_\_  
Fax \_\_\_\_\_

**Thank you for your time and input.**

**Please return the completed form to:  
Mobility Specialist  
NAIPTA/Mountain Lift  
3773 N. Kaspar Drive, Flagstaff, AZ 86004  
Or fax to: 928-779-6868**



**NOTICE OF PRIVACY PRACTICES**

**NORTHERN ARIZONA INTERGOVERNMENTAL PUBLIC TRANSPORTATION  
AUTHORITY (NAIPTA)**

Danelle Knight, HIPAA Officer, (928) 679-8926

**Effective Date: August 1, 2017**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

*We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We use these records to provide or enable the ADA Specialist to make eligibility determinations for our Paratransit transportation and Reduced Fair Programs. The medical information is obtained to determine the rates for payment of transportation services to you as allowed by the American with Disabilities Act of 1990 and Civil Rights Bill. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our HIPAA Officer listed above.*

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## **A. How Mountain Lift-Paratransit and Reduced Fair Programs May Use Your Health Information**

The application process is used to collect health information about you and stored in a locked file cabinet. This is your medical record. The medical record is the property of NAIPTA, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Payment. We use medical information about you to determine the appropriate rate for payment of the services we provide.
2. Mountain Line Paratransit and Reduced Fair Programs Operations. We may use medical information about you to operate this transportation business. For example, we may use this information to review and improve the quality of service we provide, or the competence and qualifications of our staff.
3. Scheduled Pick-up Reminders. We have an automated system that will call day prior to remind client of scheduled pick up to specify who is traveling, estimated time of pick up, location of errand. The automated message may include medical appointment information which could be left on an answering machine if you are not at home or in a message left with the person answering the phone.
4. Notification and Communication with Family. If an incident should occur while Mountain Lift Paratransit or the Reduced Fair program transportation or, in the event of your death, NAIPTA will call 911.
5. Sale of Health Information. We will not sell your health information without your prior written authorization.
6. Required by Law. As required by law, we will use your health information, but we will limit our use to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
7. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
8. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other

lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

9. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
10. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
11. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
12. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
13. Change of Ownership. In the event that this transportation business is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information.
14. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances, our business associate may provide the notification. We may also provide notification by other methods as appropriate.

## **B. When Mountain Lift-Paratransit and Reduced Fair Programs May Not Use Your Health Information**

Except as described in this Notice of Privacy Practices, NAIPTA will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize NAIPTA to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

## **C. Your Health Information Rights**

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our HIPAA Officer listed at the top of this Notice of Privacy Practices.

#### **D. Changes to this Notice of Privacy Practices**

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice with the Mountain Lift Paratransit and Reduced Fair applications at the front desk and on our Mountain Line Website.

#### **E. Complaints**

Complaints about this Notice of Privacy Practices or how NAIPTA handles your health information should be directed to our HIPAA Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Michael Leoz, Regional Manager-Pacific Region  
U.S. Department of Health and Human Services Office of Civil Rights  
90 7<sup>th</sup> Street, Suite 4-100, San Francisco, CA 94103  
Customer Response Center: 1-800-368-1019  
Fax: 202-619-3818  
TDD: 800-537-7697  
[OCRMail@hhs.gov](mailto:OCRMail@hhs.gov)

The complaint form may be found at: <https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html>

You will not be penalized in any way for filing a complaint.