JAC ASSIST
3303 Butti Way, Bldg. 1
Carson City, NV 89701
Phone: (775) 841-7433
Fax: (775) 887-2324

ADA COMPLEMENTARY PARATRANSIT ELIGIBILITY APPLICATION

PART A
Personal/Contact Information

JAC Assist provides origin-to-destination paratransit service to individuals who cannot use the regular JAC fixed-route transit system. To be eligible for service, the functional limitations of an individual's disability must prevent use of regular fixed-route bus service. The individual's distance from a bus stop or inability to drive by himself/herself are not taken into consideration in determining eligibility.

To be considered for eligibility, individuals must complete Part A of this application; and a qualified medical professional (e.g., physician [M.D. or D.O.], physical therapist, occupational therapist, orientation and mobility instructor, registered nurse, independent living specialist, rehabilitation specialist, licensed social worker, optometrist, psychologist) must verify Part A and complete Part B of this application.

Applicants will also need to complete the *Disclosure of Protected Health Information Authorization Form* attached to Part B. **Incomplete applications will be returned to the applicant**.

PLEASE TYPE OR PRINT IN INK

Last Name_____ First Name _____MI____

Address _____Apt. No._____

City/Town _____State _____Zip_____

Home Phone (____)_____ Work Phone (_____)_____

TTD/TTY (____)_____ Cell Phone (____)_____

DOB ____/____/_____ E-Mail address: _____

Do you require information in an alternative format?

Braille_____Large Print_____Audio Tape_____Other:_____

If someone is helping you with this application, that person **must** complete the following:

Name _____

Address _____

Home Phone (___) _____ Work Phone (___) _____

Emergency Contact Information:

Name _____ Relationship: _____

Home Phone: (___) _____ Cell Phone: (___) _____

Work Phone: (___) _____

INFORMATION ABOUT YOUR ABILITIES

1. What is the disability or health condition that **prevents** you from using the regular fixed-route **JAC** bus service?

___ Certified Legally Blind
___ Loss or inability to use one or more limbs
___ Severe effects of stroke
___ Paralysis affecting mobility, speech, vision or memory
___ Severe Arthritis
___ Autoimmune Disorders, for example, Lupus or Scleroderma etc.
___ Severe cardiac and/or respiratory impairment affecting strength and/or endurance
___ Severe emotional disorder (may require an escort)
___ Developmental disabilities, for example, mental retardation, cerebral palsy, epilepsy, autism or neurological disorder, etc.
___ Hearing loss accompanied by an inability to understand speech with/without a hearing aid

Other *(please explain)***:**

_____

a. Is your disability permanent? ____ Yes ____ No

b. If your disability is temporary, how long do you expect it will be until you're better?

_____Months.

c. Is there a season during the year that your disability/health condition worsens and prevents you from traveling without help? **(*Check all that apply)***

_____ Spring _____ Summer _____ Fall _____ Winter

2. Do you use any of the following mobility aids? ***Check all that apply***.

____ *Manual Wheelchair* ____ *Electric Wheelchair*
____ Powered Scooter ____ Cane
____ Walker ____ White Cane
____ Service Animal ____ Crutches
____ Oxygen ____ Other (please list) _____

If you checked service animal, please give a description of your service animal.

_____

3. Do changes in weather (like extreme heat, cold, wind, rain, snow and/or ice) combined with your disability or health condition **stop** you from using the regular fixed-route **JAC** bus service? _____ Yes _____ No

If yes, explain completely. Use an additional sheet if necessary.

_____
_____

4. Do you require the assistance of a personal care attendant (PCA) when you travel? **(*Riders must provide their own PCA*)**

_____ Yes _____ No _____ Sometimes

5. All JAC vehicles have wheelchair lifts (if you are unable to climb stairs, you can stand on the lift). Would you be able to get onto and off of a regular bus **without the help of another person?** (The driver operates the lift and helps with the securement system. Lifts have handrails.)

_____ Yes _____ No_____ Sometimes

If you answered ***No or Sometimes*****,** *explain why***:**

_____
_____

6. Does your disability or health condition **stop** you from getting to or from a bus stop without help from another person, for one of the following reasons? ***(Check all that apply.)***

___ Unable (not just difficult) to travel on rough or hilly terrain
___ Extreme sensitivity to certain weather conditions
___ Extreme fatigue due to health condition
___ Unable to cross busy intersections
___ Lack of sidewalks and curb cuts at bus stop
___ Unable to locate bus stop due to a visual impairment
___ Unable to wait outside for ten (10) minutes or more
___ Unable to travel on ice or snow covered surfaces
___ Unable to identify correct bus in the daytime when it is light
___ Unable to identify correct bus in early morning or evening hours when it is dark

___ Other
Please explain:_____
_____
_____

7. How many blocks is your home to the nearest bus stop?_____
(A city block is approximately 500 feet long)

8. Indicate below how far you are able to travel **without** help.
___ Less than 200 feet ___ ¼ mile (3 blocks) ___ ½ mile (6 blocks)
___ ¾ mile (9 blocks) ___ more than ¾ of a mile

9. After arriving at a bus stop, how long can you wait outside ***(not sitting)*** until the bus arrives?
___30 minutes or longer ___ 15 minutes ___10 minutes
___ Less than 10 minutes
If you cannot stand while waiting, *why not*?
_____

10. Which of the following functions are you **unable** to perform without assistance from another person: **(*check all that apply*)**

___ Understand and/or process information
___ Ask for, or follow written or oral information, such as schedules including TDD, audio tape or voice?
___ Figure out the correct fare?
___ Follow instructions in an emergency?
___ Recognize your destination while on the bus?
___ Once you get off the bus, locate and reach your destination?
___ Cross a busy intersection?
___ Find your way between familiar locations?
___ Signal the bus driver to get off the bus at a familiar stop and then get off the bus? *Assume the driver calls all stops.*
___ Grasp coins, passes, and handles?
___ Communicate addresses, destinations, and telephone numbers on request?
___ Deal with unexpected situations or unexpected changes in routine e.g., route changed due to road construction, regular bus stop closed?
___ Go up and down steps?

11. If training for riding on the regular **JAC** bus system were available at no charge, do you think that you would benefit from receiving this training?

_____ Yes _____ No

I understand that completing PART A is the first step in determining if I am eligible for JAC Assist ADA Complementary Paratransit Service.

Furthermore, I agree to have a **qualified medical professional** conduct an independent professional assessment of my eligibility by completing PART B of the application. I understand that failure to participate in this assessment will result in a denial of eligibility for the JAC Assist paratransit service.

I understand that the entire application (Part A, Part B and the *Disclosure of Protected Health Information Authorization Form*) must be submitted to begin the application review. In addition, I authorize the qualified medical professional completing Part B on my behalf to release my health information to JAC Assist for its review as well as any supporting or other pertinent information about my health or medical condition to assist in determining eligibility for JAC Assist paratransit service. I understand that upon receipt of this application, JAC Assist will make a determination of my eligibility within 21 calendar days. Furthermore, I understand that JAC Assist may need to contact me or a representative on my behalf regarding my application as well as possibly the qualified medical professional completing Part B to obtain more information.

I certify by my signature that I have been truthful in answering all questions in this application, and that the information I have provided is correct. I understand that providing false information could result in denial of service.

_____ _____

Applicant's Signature Date

If you assisted the Applicant to complete this Form, sign below:

_____ _____

Signature Date

JAC ASSIST
3303 Butti Way, Bldg. 1
Carson City, NV 89701
Phone: (775) 841-7433 Fax: (775) 887-2324

ADA COMPLEMENTARY PARATRANSIT ELIGIBILITY APPLICATION

PART B
Professional Verification

Dear Qualified Medical Professional:

The Americans with Disabilities Act (ADA) of 1990 requires JAC to provide **ADA Complementary Paratransit Service** to anyone who cannot use JAC fixed-route bus service because of a disability. ADA Complementary Paratransit Service is provided in an area contiguous to JAC fixed-route bus service. The applicant who has asked you to review and sign this application is applying to be considered eligible for JAC Assist ADA Complementary Paratransit Service, which is intended only for those trips that the applicant cannot make on JAC fixed-route bus service.

What is needed is a determination of whether, as a practical matter, the individual can use fixed-route transit in his or her own circumstances. This is primarily a transportation decision, not a medical decision. This application is intended to determine when and under what circumstances the applicant can use JAC fixed-route bus service and when he/she requires ADA Complementary Paratransit Service.

Please review the information provided by the applicant in **PART A** of this application and then answer the questions below:

Is the applicant **unable** to use **JAC** fixed-route service as described above?
Yes _____ No _____

If No, STOP HERE and don't complete the rest of PART B. Please sign, date and mail this page to JAC Assist, 3303 Butti Way, Bldg. 1, Carson City, NV 89701.

_____
Professional's Signature Date

_____
Printed Name License No. / State Phone Number

If you answered **Yes** to the above question, please continue to the next page and answer all of the questions. Questions regarding the application or verification may be directed to JAC Assist at (775) 841-7433.

1. Have you ever examined/evaluated the applicant in the past?
   Yes _____ No _____

   If yes, was examination/evaluation within the last twelve months?
   Yes _____ No_____

   Length of time in treatment/under your care? _____

2. What is the applicant's specific disability or health condition/limitation and how does it limit or prevent his/her ability to travel independently or utilize regular fixed-route JAC service?

   ___ Certified Legally Blind
   ___ Loss or inability to use one or more limbs
   ___ Severe effects of stroke
   ___ Paralysis affecting mobility, speech, vision or memory
   ___ Severe Arthritis
   ___ Autoimmune Disorders, for example, Lupus or Scleroderma etc.
   ___ Severe cardiac and/or respiratory impairment affecting strength and/or endurance
   ___ Severe emotional disorder (may require an escort)
   ___ Developmental disabilities, for example, mental retardation, cerebral palsy, epilepsy, autism or neurological disorder, etc.
   ___ Hearing loss accompanied by an inability to understand speech with/without a hearing aid
   ___ Other ***(Please explain the medical diagnosis and then describe the disability or health condition/limitation) Use other side of page if necessary***

   _____
   _____
   _____
   _____

   Date of onset _____

3. Is the applicant's disability permanent?
   Yes _____ No _____

   If temporary, how long? _____

   Is this applicant's disability seasonal?
   Yes _____ No _____

   If Yes, which season(s)?_____

4. What mobility aids does the applicant utilize? ***Check all that apply***.

Manual Wheelchair	____	*Electric Wheelchair*	____
Powered Scooter	____	Cane	____
Walker	____	White Cane	____
Service Animal	____	Crutches	____
Oxygen	____	Other (please list)	_____

5. Does the applicant require a Personal Care Attendant (PCA) when traveling on transit vehicles?

   Never _____ Sometimes _____ Always _____

   If a PCA is needed, explain why.

   _____
   _____
   _____

6. Which of the following weather conditions impact the applicant's disability or health condition such that it prevents him/her from independently getting to and/or from a bus stop?

   Indicate: Heat _____ Cold _____ Humidity _____ Snow _____ Ice _____
   Pollution/Allergies_____ Other_____ N/A ____

   What specific weather condition prevents this person from getting around on his/her own? How so?

   _____
   _____
   _____

7. Does rough terrain make it hard for the applicant to travel?

   Yes _____ No _____ Sometimes _____

   If you answered Yes or Sometimes, describe your definition of rough terrain and how that makes it difficult for the applicant to travel.

   _____
   _____
   _____

8. Is applicant able to: **(*Check all that apply)***

   ___ Understand and/or process information
   ___ Ask for, or follow written or oral information, such as schedules including TDD, audio tape or voice?
   ___ Figure out the correct fare?
   ___ Follow instructions in an emergency?

___ Recognize his/her destination while on the bus?
___ Once he/she gets off the bus, locate and reach his/her destination?
___ Cross a busy intersection?
___ Find his/her way between familiar locations?
___ Signal the bus driver to get off the bus at familiar stop and then get off the bus? *Assume the driver the calls all stops*
___ Grasp coins, passes, and handles?
___ Communicate addresses, destinations, and telephone numbers on request?
___ Deal with unexpected situations or unexpected changes in routine, e.g., route changed due to road construction, regular bus stop closed?
___ Go up and down steps?

Signature:_____ Date:_____

Print or Type Name:_____

Title:_____

License Number / State:_____

Business Address:_____ Phone Number:_____

City:_____ State:_____ Zip Code:_____

Disclosure of Protected Heath Information Authorization Form

I _____ authorize the qualified medical
(Printed Name of Patient)

professional _____
(Printed Name and Title of Qualified Medical Professional)

completing Part B of this application on my behalf, to release information about my disability and abilities to use the accessible JAC fixed-route bus service to representatives of JAC Assist for their review, as well as any supporting or other pertinent information about my health or medical condition to assist in determining my eligibility for JAC Assist ADA Complementary Paratransit Service. I understand that all medical information about my disability will be kept strictly confidential.

I understand that I do not have to sign this authorization in order to be considered for services, but I understand that no weight will be given to medical conditions claimed which cannot be verified. In fact, I have the right to refuse to sign this authorization. I have the right to revoke this authorization in writing except to the extent that JAC Assist has acted in reliance upon this authorization. My written revocation must be submitted to JAC Assist, 3303 Butti Way, Bldg. 1, Carson City, NV 89701.

_____
Signature of Applicant or Legal Guardian* Date

Printed Name of Legal Guardian, if applicable:_____
Legal Guardian's Relationship to Applicant:_____
Printed address & telephone number of Legal Guardian:
_____
_____

Applicant or guardian must be provided with a signed copy of this authorization form.

*This form may be signed by a legal guardian or power of attorney only if documentation showing legal authority to act and sign on the applicant's behalf is also provided. Documentation is not necessary for the parent of a minor child.