

TOLEDO AREA REGIONAL TRANSIT AUTHORITY PARATRANSIT ELIGIBILITY

RE-CERTIFICATION APPLICATION



INTRODUCTORY INFORMATION

The Americans with Disabilities Act (ADA) was passed in 1990. This federal law states that the regular transit bus system (fixed route) should serve as a primary means of transportation for everyone, including people with disabilities. The intent was to remove barriers that have prevented people with disabilities from fully participating in life, including barriers to public transportation.

TARTA Move, a shared-ride Paratransit service, is available for those individuals whose disabilities in combination with their functional abilities prevent them from using the regular ADA transit bus system (*TARTA fixed-route*) for some or all of their transportation needs. Services are provided by both TARTA Move drivers and local contracted transportation providers.

TARTA Move covers the same service area as TARTA fixed route, in addition to a three-quarter of a mile buffer around those routes. Rides on TARTA Move must be reserved one (1) to seven (7) days in advance. TARTA Move operates with a 30-minute window of arrival, meaning your ride may arrive up to 10 minutes earlier or 20 minutes later than the designated pick-up time. When rides arrive within this 30-minute window, they are considered on time.

Please keep in mind that TARTA Move is a shared ride service. Other TARTA Move riders may be picked up or dropped off before you reach your destination.

Eligibility is NOT based on:

- Age, Gender, or Race.
- A disability or medical diagnosis alone (ex: schizophrenia, cerebral palsy).
- The use of a mobility aid (ex: wheelchair, walker).
- An inability to drive.
- Personal finances.
- Neighborhood safety/crime concerns.
- Inconvenient *TARTA* fixed route bus schedules.
- Not being able to carry items on the bus (ex: books, groceries, strollers).
- Not knowing how to use the TARTA fixed route bus system

**KEEP THIS INFORMATION PAGE FOR YOUR RECORDS - DO NOT
SEND WITH YOUR APPLICATION**

INSTRUCTIONS FOR COMPLETING THIS RE-CERTIFICATION APPLICATION

This application is to be completed by the person requesting ADA Paratransit Service (or helper). Please read the definitions of eligibility in the first paragraph of the Introductory Information page carefully and consider how your disability prevents you from using *TARTA fixed routes*. Please answer each question as completely as possible. **Incomplete applications will be returned for clarification, and this will delay your eligibility determination. Both PART I and PART II are required to be completed in order for this application to be processed.** The applicant or the parent, legal guardian of a minor, or POA must sign all applications. Children under the age of 18 should be accompanied by a parent, legal guardian, or designated adult for assessments. TARTA Move reserves the right to request that applicants have someone to accompany them.

You may include additional medical diagnosis or verification forms and health information releases as you deem necessary. Additional forms may be downloaded from the TARTA website at: www.tarta.com/services/move. If you have any questions, please call the Customer Service Representatives at 419-382-9901, Monday - Sunday 9am to 5pm. For Ohio Relay service, please call 1-800-750-0750, Monday - Sunday 9am to 5pm.

Completed applications should be submitted to the TARTA Paratransit Office by mail, fax, or email.

**TARTA Move
130 Knapp St.
Toledo, OH 43604
419- 724-6659(Fax)
move-eligibility@tarta.com (E-mail)**

THE NEXT STEP

After your application is received, you may be contacted for an in-person assessment or phone review. You can request a free, round-trip TARTA Move ride for the assessment as long as you can arrange pick-up within the TARTA Move service area. The purpose of this assessment is to review your application with you, assess information and capabilities as they pertain to ADA eligibility, and determine if additional information is needed.

All applicants will have their pictures taken. You will receive a notice by mail of your eligibility status for the TARTA Move ADA Paratransit Service. If a decision regarding your eligibility has not been made within 21 business days, you may request an extension of service until the determination is made and you are notified. Per ADA regulation, TARTA is required to make an eligibility determination within 21 business days of receiving a complete application. This timeframe does not include days out of the office, vacation, holidays, or days spent waiting for information to be sent to the Eligibility Department.

ELIGIBILITY STATUS

The eligibility period ranges from less than 1 to 5 years. Riders need to reapply for certification when eligibility expires and are encouraged to submit recertification applications three (3) months in advance. Eligibility may be granted upon the following basis:

--**Unconditional** - all trips within the service area.

--**Temporary** - for a shorter defined period (less than one year) as limitations or medical conditions are expected to change.

DENIALS / APPEALS

To appeal denials or temporary eligibility, the appeals process information will be included in the notification you receive from TARTA Move of your status. Paperwork must be filed within 60 calendar days of notification.

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Toledo Area Regional Transit Authority Paratransit (TARTA Move) Re-Certification Application

PART I

SECTION 1: GENERAL INFORMATION

Title: ☐ Mr. ☐ Mrs. ☐ Ms.

TARTA Card ID: _____

Last Name: _____ **First Name:** _____ MI _____

Gender: _____ Birth date: _____ / _____ / _____

Street Address: _____ Apt. #: _____

Facility/Apartment Complex Name: _____

City: _____ State _____ Zip Code: _____

Email address: _____

Phone: (Primary) (_____) _____ - _____ (Secondary) (_____) _____ - _____

Are you a Lucas County Board of Developmental Disabilities client? ☐ Yes ☐ No

May we leave detailed messages about your application or recertification?

Via phone: ☐ Yes ☐ No Via email: ☐ Yes ☐ No

All information regarding TARTA Move is provided in writing unless otherwise specified. Do you need information given to you in another format? Specify _____

Office Use Only

Client ID: _____

Exp. Date: _____

EMERGENCY CONTACT INFORMATION

Please list the names and telephone numbers of 2 people to call in case of an emergency:

Name: _____

Relationship: _____

Phone: (Primary) (____) _____ - _____ (Secondary) (____) _____ - _____

Name: _____

Relationship: _____

Phone: (Primary) (____) _____ - _____ (Secondary) (____) _____ - _____

Designated Contact:

May we contact this person if we have any questions regarding your application? ☐ Yes ☐ No

Name: _____ Phone Number: (____) _____ - _____

Relationship to you: _____ Agency name, if professional: _____

Please check the line that best describes your current living situation:

☐ 24-hour care or skilled nursing facility.

☐ Assisted living facility.

☐ I receive agency assistance from someone who comes to my home to help with daily living activities or medical care. List help provided: _____

☐ I receive help from family members or friends. List help provided: _____

☐ I live independently (without the assistance of another person).

SECTION 2: INFORMATION ABOUT YOUR DISABILITY

1. What is the primary mobility device(s) you use for outdoor travel? Check all that apply:

- | | | |
|---|---|---|
| <input type="checkbox"/> Portable oxygen | <input type="checkbox"/> Manual wheelchair | <input type="checkbox"/> Communication board |
| <input type="checkbox"/> Service animal | <input type="checkbox"/> Power wheelchair | <input type="checkbox"/> Hearing aids |
| <input type="checkbox"/> Prosthetic limb | <input type="checkbox"/> Leg extender on wheelchair | <input type="checkbox"/> Visual assistance aids - |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Power scooter | please list: _____ |
| <input type="checkbox"/> Leg brace | <input type="checkbox"/> Folding walker | _____ |
| <input type="checkbox"/> Straight cane | <input type="checkbox"/> Non-folding walker | |
| <input type="checkbox"/> White cane | <input type="checkbox"/> Walker with seat | <input type="checkbox"/> Other (be specific) |
| <input type="checkbox"/> 3-4-pronged cane | <input type="checkbox"/> Walker with wheels | _____ |
| | | _____ |

2. **If applicable:** My wheelchair, scooter or walker is oversized to accommodate my needs.

☐ Yes

☐ No

****If yes, you may be required to provide a PCA (Personal Care Attendant) to assist with boarding and exiting the vehicle.***

3. Have you condition(s) changed since your last TARTA Move application that prohibit or interfere with regular bus travel? ☐ Yes ☐ No

If yes, please list:

Medical Condition(s)

Date Diagnosed

4. Do you currently use the TARTA Fixed Route bus line:

☐ Yes

☐ No

If yes, how often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally

SECTION 3: AUTHORIZATION TO RELEASE PROTECTED HEALTH INFO

I authorize the use or disclosure of the protected health information (PHI) as described below. By authorizing the use or disclosure of the PHI described below, I authorize the provider (doctor, social services, etc.) of the PHI (1) to open the PHI for review or inspection by the person(s) identified below, and (2) to furnish the persons(s) identified below with a copy of the PHI if he or she requests, for purposes of determining my eligibility to receive transportation services.

Date _____ Patient (Applicant) Name _____

DOB _____ Social Security Number (last 4 digits) _____

Description of PHI requested, including information pertaining to:

- (1) The applicant's documented diagnosis/health condition(s) & how these affect his/her ability to independently use the fixed route bus service.
- (2) Written and/or verbal communication between provider and TARTA Move.

I authorize the following provider (doctor, social services, etc.) of my PHI to release and/or disclose the PHI described above:

Provider _____

Address _____

Phone Number _____ Fax Number _____

I authorize the release and/or disclosure of the PHI described above to:

Toledo Area Regional Transit Authority, Paratransit Eligibility Dept.

130 Knapp Street

TEL: 419-382-9901

FAX: 419-724-6659

Toledo, Ohio 43604

EMAIL: move-eligibility@tarta.com

I, the applicant, authorize the provider to disclose the PHI described.

☐ Yes ☐ No

I understand that I have the right to revoke this Authorization, in writing, at any time by so notifying the requesting person. Such revocation will not affect the actions taken by the requesting person prior to the date he or she received the written revocation.

I understand that my health care provider cannot condition medical treatment on whether I sign this Authorization.

This Authorization will expire at the conclusion of my Paratransit Eligibility Review.

X

Signature of Applicant

Date

X

Signature of Parent/Guardian/Authorized Representative

Date

Relationship to the Applicant

NOTE: A Photocopy or facsimile shall have the same effect as the original.

SECTION 4: APPLICANT'S CERTIFICATION

In compliance with the Americans with Disabilities Act of 1990 (ADA), TARTA provides Paratransit service (other than the regular bus service) to anyone with a disability, who qualifies and who cannot use the fixed route bus system and who is traveling within ¾ mile of a scheduled fixed route. This shared-ride service is intended only for those trips that the rider cannot make on the fixed route system.

This application is intended to determine when and under what circumstances the applicant can use the shared-ride ADA Paratransit service.

I understand that the purpose of this application is to determine if there are times when I cannot use the fixed route or TARTA Flex bus system and will need to use the shared-ride Paratransit system.

I understand that all the information concerning my disability will be kept confidential and shared only with professionals that will be involved in the determination of my eligibility.

I authorize any professional organization and/or designated contact listed in this application to release information relating to my disability to the TARTA Move office in order to determine eligibility.

I certify that, to the best of my knowledge, all the information in this application is true and correct. **In the event of the change in contact information or address, it is my responsibility to notify TARTA Move.** I understand that providing false information could result in the loss of Paratransit Services. I agree to notify TARTA Move if my condition improves enough to change my eligibility status.

SIGNATURE: Please Complete Part A or B

Part A. Applicant:

Signature of Applicant

Date

Part B. Applicant is a minor, or has a guardian:

I consent to the Applicant's interview and any assessments of their travel abilities and limitations to determine ADA Paratransit Service eligibility. I understand that the Applicant and parent/legal guardian or other designee must be present for the interview/assessment process, and I acknowledge the following:

Name _____ Relationship to Applicant _____

Address _____

Phone _____ Org/Agency _____

☐ I will be present ☐ I designate _____ to be present on my behalf.

Guardian's Signature _____ Date _____

Applicant's Signature _____ Date _____

TARTA MOVE APPLICATION: PART II

To be completed by a Licensed/Certified Clinical Professional who has knowledge about the applicant's functional ability and can verify diagnoses. He/she does not have to be the one who provides treatment. ONLY THE PROFESSIONAL COMPLETES THIS PART II.

Applicant Name _____

Required Information - Licensed/Certified Clinical Professional

Name _____ Title _____

Signature **X** _____ Date _____

Professional License # _____

Clinic or Agency _____

Address _____

Phone Number _____ Fax # _____

E-mail (optional) _____

Please list all related diagnoses that affect the applicant's ability to travel in the community. List the specific diagnosis and its severity in each category. Complete each of the following sections as they apply to the applicant. (You don't need to be the one who treats the diagnosis but can verify the diagnosis and how it impacts the applicant.)

Physical Diagnoses _____

Cognitive Diagnoses _____

Mental Health Diagnoses _____

Vision Diagnoses _____

Date of last evaluation: _____ Patient/Client since: _____

Is the condition(s) temporary? ☐ Yes ☐ No If yes, what is the expected duration? _____

Describe the temporary condition: _____

We greatly appreciate your time in completing this application.



Please submit application to:

**TARTA Paratransit Eligibility Dept.
130 Knapp Street
Toledo, OH 43604
419-382-9901 (Phone)
419-724-6659 (Fax)
move-eligibility@tarta.com (E-mail)
1-800-750-0750 (Ohio Relay Service)**