MISSOULA URBAN TRANSPORTATION DISTRICT
1221 Shakespeare | Missoula, MT 59802
(406) 721.2848 | Fax (406) 543.8387
WWW.MOUNTAINLINE.COM

# Paratransit Application

## 1. Eligibility Questionnaire

This form must be completed by the applicant or someone authorized to sign on the applicant's behalf.

## 2. Professional Verification Form

All applicants must sign the Authorization for the Release of Information included in part 2, page 1. The rest of the form must be completed by a professional who is familiar with the applicant's condition and qualified to respond (see right).

## 3. Submit Both Forms Together

Submit both the **Blue Eligibility Application** and the **Green Professional Verification** together. All applications will be processed within 21 calendar days of receipt of the completed packet and the applicant will be notified in writing of Mountain Line's determination of eligibility.

## List of Qualified Professionals:

- Physician or Psychiatrist
- Physical Therapist
- Physician Assistant
- Licensed Clinical Social Worker (LCSW)(LCPC)
- Occupational Therapist
- Registered Nurse or Nurse Practitioner
- Psychologist
- Certified Orientation and Mobility Specialist
- Speech/Language Pathologist

*Mountain Line recognizes that many professionals work with clients that are disabled and the list above is not meant to exclude those professionals. In general, this will require completing a multi-year degree program and/or being licensed by the State of Montana. A primary care physician is often able to* adequately *complete this form. You do not need to visit a specialist.*

## Avoid Delays in Application Process

- All pages for both forms must be submitted
- Check that all questions have been answered
- Make sure all needed signatures are present
- Double check the professional credential section is complete

An incomplete application will be returned to the applicant one (1) time with a notice of what is missing. If it is returned to Mountain Line Paratransit incomplete a second time, the applicant will be sent a new blank application to complete.

## In-Person Assessment

The eligibility of most applicants can be determined by the forms submitted to Mountain Line staff. However, there may be cases where Mountain Line requests to conduct an in-person functional assessment of an applicant's disability. This assessment may include, but is not limited to:

- A conversation about the applicant's mobility
- Reading a bus schedule to plan out a bus trip
- Taking a short walk
- Practice boarding an actual bus

If an in-person assessment is requested, your application will still be processed within 21 calendar days of receipt. Transportation will be provided.

| App Received:_____ |
|---|
| Approved:_____ |
| Expiration Date:_____ |

# 1 Part 1 Eligibility Application

Complete the entire application. Incomplete applications will be returned.

**Is this a new application, or a recertification?** ☐ New ☐ Recertification

| Applicant Information | | | |
|---|---|---|---|
| First Name | Last Name | | Middle Initial |
| Street Address | | | Apt. # |
| City | | State | Zip Code |
| Is this an apartment complex, mobile home park, or facility?<br>☐ Yes ☐ No | | Name of complex or facility | |
| Home Phone | Mobile Phone | Email Address | |
| Preferred Notification Method<br>☐ Voice Call ☐ Text Message | | Gender<br>☐ Male ☐ Female ☐ non-Binary ☐ Prefer not to say | |
| Date of Birth (mm/dd/yyyy) | | Primary Language<br>☐ English ☐ Other _____ | |

☐ **Check this box if someone other than the applicant is completing this form and provide the following information**

| Legal Guardian Information | | | |
|---|---|---|---|
| First Name | Last Name | | Middle Initial |
| Street Address | | | Apartment # |
| City | | State | Zip Code |
| Home Phone | Mobile Phone | Relationship to Applicant (Family Member, Case Worker, etc.) | |

| In case of emergency, who should we contact? |
|---|
| Emergency Contact Name |
| Primary Phone<br>(  ) |
| Secondary Phone<br>(  ) |
| Relationship |

| Who is authorized to contact Mountain Line on your behalf? |
|---|
| Contact Name 1 (Individual or Organization) |
| Phone<br>(  ) |
| Contact Name 2 (Individual or Organization) |
| Phone<br>(  ) |

# A General Information

How long would you like to use the service? ☐ Temporarily ☐ Permanently (Recertification is required every 2 years)

**What is your current primary transportation option?**

☐ Walking
☐ Drive myself
☐ Ride with somebody
☐ Taxi
☐ Fixed Route Bus
☐ Bicycle
☐ Mountain Line Paratransit
☐ Other, specify: _____

**Can you use the fixed route bus without someone else's help?**

☐ Yes, I currently ride the Fixed Route Buses
☐ I only ride with assistance from others.
☐ I only ride when the bus stops are accessible.
☐ No, I have never ridden.
☐ I do not ride anymore because:_____

**Mountain Line provides free, in-person training to help you learn to ride our Fixed Route Buses. Would you be interested in this as an alternative?**

☐ No ☐ Yes ☐ Possibly, please contact me.

**Do you require a Personal Care Attendant to travel with you?**

☐ No ☐ Yes ☐ Sometimes, specify:_____

**Do you travel with a Service Animal?** ☐ No ☐ Yes, Type: _____

# B Required Assistance

**What mobility device(s) will you be using?** (Note: Larger mobility devices and devices that exceed 600 pounds when occupied may exceed equipment transport capacity.)

☐ Cane
☐ Crutches
☐ Walker
☐ White Cane
☐ Prosthesis
☐ Portable Oxygen
☐ Manual Wheelchair
☐ Powered Wheelchair or Scooter
☐ No aid required

**What is your estimated bodyweight?** _____ lbs.

**Are you able to complete the following tasks without assistance from another person?**
Check a box for each question. If you answer sometimes for any questions please explain.

| | | | |
|---|---|---|---|
| **A.** Get to/from a bus stop? | ☐ Always | ☐ Never | ☐ Sometimes |
| **B.** Walk or travel using a mobility device for 3 blocks? | ☐ Always | ☐ Never | ☐ Sometimes |
| **C.** Get on/off a fixed route bus **without** using the lift or ramp? | ☐ Always | ☐ Never | ☐ Sometimes |
| **D.** Get on/off a fixed route bus using the lift or ramp? | ☐ Always | ☐ Never | ☐ Sometimes |
| **E.** Climb three 10-inch steps? | ☐ Always | ☐ Never | ☐ Sometimes |
| **F.** Wait at a bus stop while standing for 15 minutes? | ☐ Always | ☐ Never | ☐ Sometimes |
| **G.** Wait at a bus stop while sitting for 15 minutes? | ☐ Always | ☐ Never | ☐ Sometimes |
| **H.** Maintain your balance entering, exiting, and riding a fixed route bus? | ☐ Always | ☐ Never | ☐ Sometimes |
| **I.** Understand and follow verbal directions? | ☐ Always | ☐ Never | ☐ Sometimes |
| **J.** Recognize correct stops and landmarks to complete a trip? | ☐ Always | ☐ Never | ☐ Sometimes |
| **K.** Hear stops announced by the operator? | ☐ Always | ☐ Never | ☐ Sometimes |
| **L.** Read and follow informational signs? | ☐ Always | ☐ Never | ☐ Sometimes |
| **M.** Plan a trip using a bus schedule? | ☐ Always | ☐ Never | ☐ Sometimes |
| **N.** Clearly communicate information about yourself? | ☐ Always | ☐ Never | ☐ Sometimes |

**Please explain any boxes checked Sometimes:** _____
_____
_____
_____

## C Disability Information

*These questions help describe your disability and how it may impact you.*

**What is your disability?** _____
_____
_____

**Is your disability:**
☐ Permanent ☐ Stable ☐ Progressive ☐ Temporary, how long? Months_____Years_____

**Explain how your disability prevents you from the following:**

*Please provide a complete and specific answer. Attach an additional page if needed.*

- Getting on or off a lift/ramp equipped Fixed Route Bus; and/or
- Getting to or from a bus stop; and/or
- Successfully completing a bus trip

_____
_____
_____
_____
_____
_____
_____
_____

**How far can you travel on level ground?** (With your mobility aid, if any.)

☐ Less than one block ☐ Two blocks ☐ Three blocks ☐ Four blocks or more

**Can you, with a mobility aid if needed:**

| | |
|---|---|
| Self-ambulate from your threshold to curbside? | ☐ Yes ☐ No |
| Wait at the street curb for a ride? | ☐ Yes ☐ No |
| Wait at the front door/lobby for your ride? | ☐ Yes ☐ No |

(Note: Mountain Line operators are not allowed to cross the outer threshold of any residence, facility or business.)

**Does your disability prevent you from using Fixed Route service seasonally?**

☐ No, my inability to ride is not weather related.
☐ Yes, I can only ride Fixed Route Buses in the summer.
☐ Yes, I can only ride Fixed Route Buses in the winter.

**Does your disability change daily in ways that could disrupt your ability to use Fixed Route Bus service?**

☐ No ☐ Yes, please explain: _____
_____

**Please list three trips you frequently take:**

| | Starting Address | Ending Address |
|---|---|---|
| **1.** | _____ | _____ |
| **2.** | _____ | _____ |
| **3.** | _____ | _____ |

## D Application Signature

I understand that the purpose of this application is to determine if the applicant is eligible to use ADA Paratransit Service. I certify that the information provided in this application is true and correct. **I understand that falsification of information could result in the denial of ADA Paratransit services as well as a penalty under the law.** I agree to notify Mountain Line if my circumstances change and I no longer need to use ADA Paratransit Services. I understand that I am responsible for authorizing a Professional Verification of my condition(s). I also understand that a follow-up conversation, an informational meeting or functional assessment by a professional selected by Mountain Line may be requested.

**Applicant or Guardian Signature:** _____

**Date:** _____

**The following pages must be sent to your Health Care Provider *after* you complete section 2, page 1, Information Release.**

**Part 1 Completed.**

2

**Part 2 Mountain Line Paratransit**

# Professional Verification

Complete the entire application. Incomplete applications will be returned.

## Information Release

### Medical Information / HIPAA Authorization

I, _____ authorize the healthcare provider (listed below), and their office completing this application to release to Mountain Line any protected health information about my disability in order to verify my eligibility for Paratransit service. I also authorize the release of further information should it be needed for this application for a period of 60 days from the date of my signature on this application unless revoked in writing.

| | |
|---|---|
| Applicant Signature | Date |
| Applicant Name (printed) | Date of Birth |
| Applicant Address | Applicant Phone # |

### Your Health Care Provider

| Health Care Provider | | |
|---|---|---|
| **Provider** | **Profession** | |
| **Address** | **Phone** | **Fax** |

**The following pages must be filled out by your Health Care Provider.**

MISSOULA URBAN TRANSPORTATION DISTRICT
1221 Shakespeare | Missoula, MT 59802 (406) 721.2848 |
Fax (406) 543.8387
WWW.MOUNTAINLINE.COM

**Dear Healthcare Professional:**

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

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

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

**All information provided will remain confidential. If you have any questions, please call 721-2848.**

**Thank you for your assistance,**

**Mountain Line Paratransit Services**

# A General Disability Questions

**Describe the diagnosed disability or disabilities that you are currently treating this individual for?**

_____
_____
_____
_____
_____
_____

**Check all that apply**

**Is the patient's disability:**

☐ Permanent ☐ Stable ☐ Progressive ☐ Temporary - How long? Months_____Years____

**Does your client's disability:**

☐ Affect mobility ☐ Affect judgment ☐ Require use of a mobility aid

☐ Require them to have a PCA when traveling outside their residence (checking this box means that the client cannot travel safely without a PCA)

**Can your client:**

| | |
|---|---|
| **A.** Walk two blocks (600 feet) with their mobility aid? | ☐ Yes ☐ No |
| **B.** Climb three standard steps without assistance? | ☐Yes ☐ No |
| **C.** Stand without support for 15 minutes? | ☐ Yes ☐ No |
| **D.** Walk or stand without debilitating pain or discomfort? | ☐ Yes ☐ No |
| **E.** Board or de-board a fixed route bus equipped with a lift or ramp? | ☐ Yes ☐ No |
| **F.** Recognize correct stops and landmarks to complete a trip? | ☐ Yes ☐No |
| **G.** Hear and understand verbal information? | ☐ Yes ☐ No |
| **H.** Read and understand informational signs? | ☐ Yes ☐No |
| **I.** Plan a trip using public transportation? | ☐ Yes ☐ No |
| **J.** Communicate information about themselves? | ☐Yes ☐ No |

## B Disability Specific Questions

**ICD 11/DSM Code for the condition(s) you are treating:** _____

**WHODAS Score** (if citing a cognitive or psychological disorder): _____

**Please only complete those questions that apply to the applicant for this section.**

**Does the applicant experience seizures?** ☐ No ☐ Yes

**Is the applicant's judgment impaired?** ☐ No ☐ Yes

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

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

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

**Please describe any triggers that may cause psychological disorders to manifest**.

_____
_____
_____
_____
_____
_____
_____

**Please describe the functional limitations caused by this impairment.**

_____
_____
_____
_____
_____
_____
_____

## C Mobility and Safety Questions

**Does the applicant have a visual impairment that affects their ability to move about in the environment?**

☐ No ☐ Yes If yes, please explain: _____

_____

_____

_____

_____

_____

**Has the applicant received any orientation & mobility training?**

☐ No ☐ Yes If yes, please explain: _____

_____

_____

_____

_____

**Please list any side effects of medication the applicant experiences that could affect transporting them safely.** _____

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

# D Provider Affirmation

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

**Provider Signature and Affirmation**

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

_____ _____

Provider Signature Date

_____

Provider Name (printed)

**Part 2 Completed.**

3

**Part 3 Mountain Line Paratransit**

# Submit Both Forms Together

Complete the entire application. Incomplete applications will be returned.

**Make sure all questions have been answered, and required signatures are in place.**

**Submit both the BLUE Eligibility Application and the GREEN Professional Verification Form.**

**Mail to:** **Mountain Line Paratransit**
1221 Shakespeare Street
Missoula, MT 59802-2307
Fax #: (406) 543-8387

**You may also submit all forms in person at the address above, M-F, 7:00 am – 5:00 pm.**

**All applications will be processed within 21 calendar days of receipt of a completed packet and the applicants will be notified in writing of Mountain Line's determination of eligibility.**

### In-Person Assessment

You will be contacted if an in-person assessment is required. If an in-person assessment is requested, your application will still be processed within 21 calendar days of receipt. Transportation will be provided.

**Thank you for completing the Paratransit Application. Please make sure that all questions have been answered, signatures gathered, and both forms are included in your submission. We look forward to serving you.**