Athens-Clarke County Transit
Application for The Lift Paratransit Service

The Lift Application is available in accessible formats upon request by contacting Alex Crayton at Alex.Crayton@accgov.com or 762-400-6555.

What is Paratransit Service?

The Americans with Disabilities Act of 1990 (ADA) is a civil rights bill that bans discrimination against people with disabilities. Under the ADA, transit agencies operating a fixed-route system must provide a comparable travel system for people with disabilities who cannot use the fixed-route system.

The Lift is the transportation service of the Athens-Clarke County Transit (ACC Transit) for persons with a functional disability who are unable to use ACC Transit fixed-route bus for some or all of their trips due to the effects of their disability. The Lift is a “Shared Ride” service that operates at the same times and in the same areas as the fixed-route buses and trains with very few exceptions. The Lift operates in full compliance with the Americans with Disabilities Act.

Eligibility is not based solely on a diagnosis or type of disability.

Individuals are eligible based on three categories:

1. **Inability to Navigate the System Independently**
   Any person who is unable to board, ride, or exit any accessible ACC Transit fixed-route bus without the assistance of another person, other than the operator, as a result of a physical, visual, or mental disability.

2. **Lack of Accessible Vehicles, Stations, or Bus Stops**
   If accessible vehicles are not available or if a boarding or disembarking location is not accessible on the routes that the customer wishes to travel on.

3. **Inability to Reach a Boarding Point or Final Destination**
   Any person with a functional disability who has a specific impairment related condition that prevents them from being able travel, all or some of the time, to an ACC Transit fixed-route bus stop.

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The Lift service area is defined as up to one (1) mile on either side of an existing bus route. Service is available on the same days and times as fixed-route service of the requested route. If you have a disability that prevents you from using the regular fixed-route service, you may be eligible for Paratransit.

The Lift, ADA paratransit service, is considered a premium service, and agencies by law, can charge a fare that is double the standard fixed route fare. All Lift customers are expected to pay the current fare for each ride. Fare cost is subject to change at any time. Contact ACC Transit for the current fare structure or visit our website at accgov.com/transit.

ACCT Paratransit Service

Is Not - a social service sponsored transportation program or for special event group trips. It is not designed to meet the needs of every disabled person; some people may require more service or assistance than The Lift can provide.

Is Not - for individuals who **can use the regular ACC Transit buses** but prefer not to.

Is Not - door **through** door service. Drivers do not escort passengers inside buildings. They will escort passengers to and from outer doors only.

Is Not - responsible for custodial care of our passengers.

Does Not - provide mobility aids for passengers.

What is ACCT Fixed Route Service

- ACC Transit buses operate along fixed-routes on an established schedule.
- They are 100% accessible with lifts, ramps, low floors and the ability to kneel.
- They have priority seating for people with disabilities and seniors.
- They have stop announcements (*automated or by the operator*).
- They have places to secure wheelchairs or scooters.
- The service is currently fare free. ACC Transit fixed-route service operates in full compliance with the Americans with Disabilities Act (ADA).

Athens-Clarke County Application for The Lift, ADA Paratransit Service

Instructions
To help us determine your eligibility for The Lift, please complete the following application as thoroughly as possible.

All applications must be completed in their entirety or they will be returned to the applicant for completion before being processed.

Please Note:
Lift service can accommodate mobility devices up to 800 pounds when occupied. ACC Transit Fixed-route buses can accommodate devices up to 1000 pounds when occupied.

To Apply:

1. **You or your designee must complete pages 4–9. You must sign sections V and VI onpage 9. Your Licensed MedicalHealth Professional must complete pages 14–16 or 17–18 depending on the disability.**

2. Email your application to: transitdispatch@accgov.com
   or Mail your application to:
   The Lift ADA Eligibility
   325 Pound Street
   Athens, GA 30601

3. Once your completed application has been received, you may be scheduled for an "Eligibility & Assessment" interview. **ACC Transit willcontact you to schedule the appointment.**

4. After the completion of the "Eligibility Interview & Assessment" process, you will be notified of your ADA eligibility status within 21 calendar days; if determined eligible, you will be provided with instructions on obtaining your ADA Paratransit ID Card.

What to Bring to the Interview:

- A valid, **non-expired** state issued photo identification card
- A valid Medicaid identification card (if applicable)
- Mobility device that will be used when riding on Paratransit (cane, service animal, wheelchair, power chair, etc.)

Athens-Clarke County Transit
Application for The Lift Paratransit Service

Please complete this application as thoroughly as possible and to the best of your ability. If there are questions that you cannot answer, or if you need assistance to complete this form, please call **ADA Registration Office at (762) 613-3435.** To be considered complete, every question on the application must be answered. If not, it will be returned to you for completion. Your licensed physician or health care professional must complete Part IX of this application, the Medical Professional Certification.

PART I: APPLICANT INFORMATION

PLEASE PRINT/ TYPE IN BLUE OR BLACK INK

☐ New Applicant ☑ Recertification - ID#_____

Name: _____
First M.I. Last

Street Address: _____

City:_____State:_____Zip: _____

Day Phone: _____ Evening Phone: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Are you a Medicaid recipient? ☐ Yes ☐ No

Emergency Contact Person: _____

Day Phone:_____Evening Phone: _____

Relationship to Applicant: _____

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PART II: DISABILITY AND HEALTH CONDITION INFORMATION

1. What disability have you been diagnosed with?

_____

_____

2. Date of diagnosis: _____

3. Does your disability prevent you from using the regular bus service?

☐ Yes ☐ No

If yes, please explain:

_____

_____

4. Is your disability considered permanent? ☐ Yes ☐ No

If no, how long do you expect to have this disability?

_____

5. Does your disability change from day to day or seasonally? ☐ Yes ☐ No

If yes, please explain:

_____

_____

6. Does your disability make it difficult for you to understand and remember how to find your way to and from the bus stop? ☐ Yes ☐ No

If yes, please explain:

_____

_____

PART III: MOBILITY INFORMATION

7. Do you currently use any mobility aids or specialized equipment? ☐ Yes ☐ No

   If yes, please select all that apply:

   ☐ Manual wheelchair ☐ Motorized Wheelchair ☐ Scooter
   ☐ Service Animal ☐ Cane ☐ Crutches
   ☐ Brace(s) ☐ Portable Oxygen ☐ Walker
   ☐ White Cane ☐ Communication Board ☐ Prosthesis

   ☐ Other (please specify): _____

8. If you use a wheelchair or scooter, is the combined weight of you and the device over 800 pounds? ☐ Yes ☐ No ☐ Not applicable

9. If you use a wheelchair or scooter, does your residence have a wheelchair ramp?

   ☐ Yes ☐ No ☐ Not Applicable

   If no ramp, how many steps? _____

   If more than one step, how do you transport your wheelchair to the street level?

   _____

   _____

PART IV: CURRENT TRAVEL INFORMATION

10. Have you ever used the regular fixed bus service? ☐ Yes ☐ No

    If no, why not?

    _____

    _____

11. Do you currently use the fixed regular bus service? ☐ Yes ☐ No

    If yes, which routes do you use?

    _____

    _____

    If yes, what difficulties do you have when riding the bus service?

    _____

    _____

    _____

12. Do you need someone to accompany you when you travel outside the home (i.e. Personal Care Assistant), someone designated or employed to specifically help with personal needs)? ☐ Yes ☐ No

    If yes, what assistance does that person provide for you?

    _____

    _____

13. Can you get to and from the bus stop nearest to your home by yourself?

    ☐ Yes ☐ No If no, explain why not?

    _____

    _____

14. Does weather affect your ability to use the bus system? ☐ Yes ☐ No

If yes, please explain.

_____

_____

15. Have you ever received training on how to use the bus system?

☐ Yes ☐ No If yes, which agency provided the training and when?

_____

If yes, did you successfully complete the training? ☐ Yes ☐ No

16. Would you like to receive travel training? ☐ Yes ☐ No

17. How would you describe the terrain where you live?
(e.g., flat, steep hills, gradual sloping hills, etc.)

_____

18. Are there sidewalks in your neighborhood? ☐ Yes ☐ No

19. Are there sidewalks at the closest bus stop? ☐ Yes ☐ No

20. List the 3 most frequent destinations you travel to and how you get there now:

	Location 1	Location 2	Location 3
Destination Name:			
Address:			
How frequently do you travel there (within a month)?			
How do you get there now?			

21. How many blocks are from your residence to the nearest bus stop?

☐ Less than 2 blocks ☐ 2 to 4 blocks ☐ Not sure
☐ 5 to 7 blocks ☐ More than 7 blocks

22. How many blocks are there from your most frequent destination to the nearest bus stop?

☐ Less than 2 blocks ☐ 2 to 4 blocks ☐ Not sure
☐ 5 to 7 blocks ☐ More than 7 blocks

PART V: APPLICANT CERTIFICATION

I understand that the purpose of this application is to determine if I am eligible for ACCTD's The Lift services and that ACCTD staff may need to talk to me later to get more information. I understand that I may be required to attend an in-person interview or functional ability assessment as part of this application process.

By signing this application, I certify that I have been truthful in answering this form and that the information that I have provided is correct to the best of my knowledge. I understand that falsification of this information could result in a loss of The Lift service.

I agree to notify ACCTD if I no longer need to use The Lift service.

_____ _____

Applicant Signature Date

OR, if applicant is unable to sign:

_____ _____

Authorized Representative Printed Name Relationship to Applicant

_____ _____

Authorized Representative Signature Date

(By signing here, you are verifying that you are authorized to represent the applicant stated in this application.)

PART VI: APPLICANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize the professional(s) listed below to release to ACCTD information about my disability and health condition and its effect on my ability to travel on ACCTD buses. I understand that I may revoke this authorization at any time.

All medical information, which you or your health care professional provide, will be kept confidential to the extent permitted under the law, except that the information may be shared with other professionals or agencies involved in the determination of your eligibility.

Licensed Medical Professional Information:

First Name | Last Name | Title (e.g. MD, NP, PA

Telephone Number | Agency/Organization

Applicant or Authorized Signature | Date

PART VII: NOTICE TO HEALTH CARE PROFESSIONAL

Dear Health Care Professional:

Athens-Clarke County Transit Department offers two programs for a person who has been medically diagnosed with a disability. The **Fixed-Route Disability Discount Fare Program** and **Paratransit "Origin-to-Destination" Service.**

<u>Fixed-Route Disability Discount Fare Program:</u> (Currently 1/2 of the current one-way fare

To be eligible for the Fixed-Route Disability Discount Fare Program, you must have a medically documented disability and be able to perform the following transit related functions:

- Getting on or off a standard ACCTD bus
- Standing in a moving ACCTD bus
- Reading information signs (Legal blindness of 20/200 with best possible correction (tunnel vision) or a field of vision that is less than 20 degrees in the better eye, or a reduction in eyesight of the visual field. (Hemianopia))
- Hearing directions (Average loss of 30 decibels within speech frequencies in both ears, with the best possible correction is the minimum requirement)

- Understanding information signs and/or directions of the bus operator

<u>Paratransit "Origin-to-Destination" Service:</u> (Please check current fare)

To be eligible for Paratransit service a person must have a medically documented disability that limits their functional abilities to ride fixed-route (bus system). If the disability prevents a person from using a regular bus, with lift/ramp-equipment some or all of the time, they may be eligible for Paratransit service.

Paratransit eligibility is broken into three categories:

1. Inability to navigate the system independently, due to a physical or mental impairment.
2. Lack of accessible vehicles, stations, or bus stops.
3. Inability to get to and/or from a bus stop or station.

Federal Law requires that the Athens-Clarke County Transit provide Paratransitservices to persons with disabilities who cannot use our bus transit system. The information you provide in the attached Professional Verification will allow ACCTD's representatives to make an appropriate evaluation of the applicant and determine how we may best meet their needs.

Your evaluation of each person must be based solely upon their functional abilities to use regular fixed-route transit service. Your verification should consider only the presence of a disabling condition, not the applicant's age or economic status. Please exercise care in evaluating applicants for this service. False verification could result in travel limitation for persons legitimately qualified to use Paratransit.

PLEASE NOTE:

This does not include persons who find it uncomfortable or inconvenient to get to and from bus stops.

If you have any questions about the Application or the review process, please contact the Athens-Clarke County Transit Department - The Lift Registration Office at (706) 613-3435.

If you must disclose protected health information about the applicant, we have provided the applicant with an Authorization to Disclose Protected Health Information and have asked them to provide an executed copy to your office with this application.

List of Medical Health Professionals appropriate for the following disabilities

(A Licensed Medical Professional or Primary Care Physician must complete the health form.)

Disability	Licensed Professional Health Physician
Back & Spinal Related Injuries	Rheumatologist
Psychiatric / Mental Impairment	Psychiatrist or Clinical Psychologist
Neurological Impairment (Tourette's, MS, Epilepsy, Head Trauma)	Neurologist
Extremities	Orthopedist, Phys. Therapist, Rheumatologist
Heart Impairments	Cardiovascular
Diabetes	Endocrinologist / Internist
Hearing Impairments	Audiologist or Otolaryngology
Vision Impairment	Ophthalmologist/Optometrist
Blood Disorders	Hematologist
Respiratory	Pulmonologist
Musculoskeletal	Orthopedist, Rheumatologist
Intellectual Disability	Special Education Teacher/Guidance Counselor (Students Only), Psychiatrist, Psychologist
Cancer	Oncologist
Digestive Impairment	Gastroenterologist
Dementia	Neurologist, Psychiatrist
Speech Impairment	Speech Pathologist
Other Disability	Licensed Physician or Medical Professional

All Disabilities must be certified by a Licensed Medical Professional as described above.

PART VIII: MEDICAL PROFESSIONAL VERIFICATION

To be completed by your licensed Physician or Health Care Professional

PLEASE PRINT.

Name of applicant: _____

Date of applicant's last visit: _____

Medical diagnosis of disability:

_____

_____

Please discuss the impact this disability has on the applicant's ability to function:

_____

_____

_____

1. Is disability/condition permanent? ☐ Yes ☐ No

   If temporary, when will applicant be able to resume normal travel patterns?

   Date:_____/_____/ _____

2. Is disability/condition intermittent? ☐ Yes ☐ No

3. Under what circumstances does disability/condition flare-up?

   _____

   _____

   _____

4. Does the applicant have the mental capacity, visual and/or hearing ability to:

   Give addresses and phone numbers? ..... ☐ Yes ☐ No
   Recognize a destination or landmark? ..... ☐ Yes ☐ No
   Deal with unexpected change in routine? ..... ☐ Yes ☐ No
   Ask for, understand and follow directions? ..... ☐ Yes ☐ No
   Safely travel through crowded/complex facilities? ..... ☐ Yes ☐ No

5. Are there any other medical conditions which ACCTD should be aware of? ☐Yes ☐No

   If yes, explain:

   _____

   _____

6. How far can the applicant walk without assistance?
   ☐Less than one city block? (200ft.)
   ☐If more than one city block, how many blocks? _____

7. Can the applicant walk up 3 stairs (12-14 inch) without assistance? ☐Yes ☐No

8. Can applicant grip a handrail? ☐Yes ☐No

9. Does the applicant use a mobility device? Please check all that apply:

☐ Manual wheelchair	☐ Motorized Wheelchair	☐ Scooter
☐ Service Animal	☐ Cane	☐ Crutches
☐ Brace(s)	☐ Portable Oxygen	☐ Walker
☐ White Cane	☐ Communication Board	☐ Prosthesis

   ☐ Other (please specify): _____

10. Does the disability prevent the applicant from getting to/from and/or riding the bus system?

    ☐Yes ☐No

    (A) From using the Fixed route system? ☐Yes ☐No

    (B) Paratransit? ☐Yes ☐No

    If yes to any of the above, explain.

    _____

    _____

11. Does weather impact applicant's ability to travel? ☐Yes ☐No

    If yes, please explain weather conditions and effects?

    _____

    _____

    _____

12. Does applicant require a personal care attendant? ☐Yes ☐No

THIS CERTIFICATION HAS BEEN COMPLETED BY A LICENSED MEDICAL PROFESSIONAL:

Licensed Medical Professional Information:

First Name Last Name Title (e.g. MD, NP, PA)

License/certification number: _____

Which hospital/agency are you affiliated with?_____

Hospital/Agency name: _____

Address: _____

City:_____State:_____Zip: _____

Office phone #:_____Fax #: _____

I certify that the information contained in this application is true and correct to the best of my knowledge and ability. I hereby verify that the diagnosis of disability listed has been reviewed by me, is accurate and true, and represents the current physical and/or mental condition of the applicant named in this form.

Signature_____ Date:_____/_____/_____

PART IX: MEDICAL PROFESSIONAL VERIFICATION

Cognitive impairment disability: To be completed by your Psychologist or Psychiatrist

(PLEASE PRINT OR TYPE CLEARLY)

Name of applicant: _____

What is the applicant's specific disability or impairment?

_____

_____

1. How does this condition affect the individual's ability to use fixed-route bus service?

   _____

   _____

   _____

2. **Is this person able to?**
   Give address and telephone number on request ..... ☐ Yes ☐ No
   Recognize streets and bus numbers ..... ☐ Yes ☐ No
   Sign his/her name ..... ☐ Yes ☐ No
   Deal with an unexpected situation ..... ☐ Yes ☐ No
   Ask for and understand directions ..... ☐ Yes ☐ No
   Be left alone on a transit vehicle ..... ☐ Yes ☐ No

3. **Is this condition:**
   Subject to significant improvement with treatment? .....☐ Yes ☐ No
   Likely to become worse? .....☐ Yes ☐ No

4. Should this person be accompanied while using paratransit service? ☐Yes ☐No

5. Is there any other effect of the condition which ACCTD should be aware of? ☐Yes ☐No

   Please describe:

   _____

THIS CERTIFICATION HAS BEEN COMPLETED BY A LICENSED MEDICAL PROFESSIONAL:

Licensed Medical Professional Information:

First Name Last Name Title (e.g. MD, NP, PA)

License/certification number: _____

Which hospital/agency are you affiliated with?_____

Hospital/Agency name: _____

Address: _____

City:_____State:_____Zip: _____

Office phone #:_____Fax #: _____

I certify that the information contained in this application is true and correct to the best of my knowledge and ability. I hereby verify that the diagnosis of disability listed has been reviewed by me, is accurate and true, and represents the current physical and/or mental condition of the applicant named in this form.

Signature_____ Date:_____/_____/_____