

FOR MTA USE ONLY
DO NOT WRITE IN THIS BOX

Application Received: _____ Certification Date: _____ Status: Eligible Denied Conditional _____
Entered ParaPlan: _____ Letter Sent: _____ Appeal Date: _____
Eligibility Period: 3 years 1 year Visitor Temporary for _____
PCA Confirmed by: _____ Date: _____



Manchester Transit Authority Stepsaver Paratransit Eligibility Application

The MTA is committed to ensuring equal access to its services for all individuals, regardless of disability. All of the information provided in this application is confidential and serves to determine eligibility only. If you meet the eligibility criteria, you will be scheduled for an interview for final eligibility status determination.

Please note that we may not be able to accommodate you if your mobility device is longer than 48", wider than 30", or if your total weight is more than 600 lbs. Also note that age, distance to a bus stop, lack of bus service, or illiteracy, by themselves do not qualify individuals for the ADA StepSaver service. Visitors who are eligible under ADA in other cities or states are welcome to use our service while visiting for up to twenty-one (21) days.

Please return the completed application to: **Manchester Transit Authority
StepSaver Program
110 Elm Street
Manchester, NH 03101**

PART A: TO BE COMPLETED BY APPLICANT

NOTE: PLEASE ANSWER ALL QUESTIONS.

INCOMPLETE APPLICATIONS CANNOT BE PROCESSED.

Please Type or Print Clearly

Applicant Name: (First, Last, Initial) _____

Home Address: _____ Apt# _____

City: _____ State: _____ Zip Code: _____

New Application Renewal Application Temporary Application Visitor Application

Home Phone #: _____ Second (Evening) Phone #: _____

Male Female Date of Birth: ____/____/____ SSN (optional) ____ - ____ - ____

Will you need future materials in an accessible format? If yes, circle one:

Braille Large Print Audio Cassette Computer Disc

Person or agency to contact in case of an emergency:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Email Address: _____

Do you already have an MTA ID card? Yes No

PART B: APPLYING FOR ADA CERTIFICATION

1. Which of the following mobility aids or equipment do you use to help you get to where you need to go?

Please check all that apply.

- | | |
|--|--|
| <input type="checkbox"/> Manual wheelchair | <input type="checkbox"/> Respirator/Oxygen tanks |
| <input type="checkbox"/> Power scooter | <input type="checkbox"/> Guide cane |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Service animal (guide dog, etc) |
| <input type="checkbox"/> Cane | <input type="checkbox"/> I do not use a mobility aid |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Prosthetic device/brace | _____ |

(Note: We may not be able to accommodate you if your wheelchair or scooter is longer than 48", wider than 30", or if your total weight with your mobility device is more than 600 pounds)

2. Using a mobility aid, equipment, or standing on your own, what is the longest length of time that you can wait for transportation?

- | | |
|--|---|
| <input type="checkbox"/> 1-15 minutes | <input type="checkbox"/> 45-60 minutes |
| <input type="checkbox"/> 15-30 minutes | <input type="checkbox"/> Over 60 minutes |
| <input type="checkbox"/> 30-45 minutes | <input type="checkbox"/> I cannot wait without assistance |

3. Using a mobility aid, equipment, or walking on your own, how many blocks can you travel on level ground? Circle the answer below that best describes your situation.

- | | | | |
|----------------------|-------|-----------|--------|
| 1-2 blocks | Never | Sometimes | Always |
| 2-4 blocks | Never | Sometimes | Always |
| 4-6 blocks | Never | Sometimes | Always |
| 6-8 blocks | Never | Sometimes | Always |
| Over 8 blocks | Never | Sometimes | Always |

4. Do you currently use the MTA fixed route bus system?

- Yes No

• If no, please check all that apply:

- I have a disability that prevents me from boarding an MTA bus.
- I have no knowledge of or experience with the MTA bus system, so I do not know if I am able to use it.
- I cannot get to a bus stop by myself because I get disoriented or confused.
- I have an episodic disability. I can use the bus on those days when I am feeling well, but am unable to do so sometimes.
- I do not want to ride the fixed route bus system
- There are no curb cuts, paved sidewalks, or the ground is too uneven
- Other (please specify) _____

5. If you do not ride the fixed route bus system, what would help you?
- Please check all that apply:
 - Lift accessible buses.
 - Knowing more about the fixed route bus system
 - I would travel if there were accessible fixed bus routes where I need to go.
 - Other (please specify) _____
6. Can you follow written or oral instructions to use the fixed route bus system?
- Yes No
7. Can you transfer from one regular fixed bus route to another?
- Yes No
8. Can you climb three 12-inch steps without assistance?
- Yes No No, because I use a mobility aid
- If no, please explain: _____
9. Can you communicate with the bus driver by yourself?
- Yes No
- If no, please explain: _____
10. Do you travel with a Personal Care Attendant (PCA, e.g., a person such as a home attendant or friend who assists you when you travel outside your home)?
- Yes No
11. Is your condition affected by the weather?
- Yes No
- If yes please explain: _____
- _____

If you are not the applicant, but you completed this application on behalf of the applicant, you must provide the following information (please print or type):

Name of person filling out this application: _____

Relationship to applicant: _____ Phone Number: _____

Agency: _____

Address: _____

PART C: APPLICANT AGREEMENT AND INFORMATION

AGREEMENT TO ELIGIBILITY TERMS AND CONDITIONS

I understand that my application will be returned if it is incomplete and this will delay the processing of my application. I affirm that all information that I provide on this application is true to the best of my knowledge. I understand that my application is subject to review and verification and that misrepresentation of any material information will lead to revocation of my registration. I also understand that failure to adhere to the policies and procedures for using the MTA StepSaver service will be grounds for suspending my eligibility in this program.

I agree to notify the MTA if I no longer need to use this service.

X _____
Signature of Applicant or Responsible Party *Date*

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the professional who has completed PART D of this application to release information about my disability or health condition and its effect on my ability to travel on the MTA fixed bus route service. I understand I may revoke this authorization at any time. Unless earlier revoked, this form will permit the professional completing PART D to release the information described up to 90 days from the date below. I understand that all medical information provided about my disability or health condition will be kept strictly confidential within the limits of the law.

X _____
Signature of Applicant or Responsible Party *Date*

AMERICANS WITH DISABILITIES (ADA) APPEAL PROCESS

If your ADA paratransit eligibility determination results in a finding of ineligible to receive paratransit service or in a determination of limited or conditional eligibility and you feel that this determination has been made in error, you have the right to appeal this determination.

To file this appeal you must notify the MTA in writing within 60 days of the date on the determination letter. After your appeal is received, a hearing will be scheduled to evaluate your case. The Assistant Executive Director of the MTA will serve as the appeal officer. The hearing process (which should not take more than 30 days) will allow you to present information and arguments on your behalf. You may have others present who are knowledgeable of your physical or mental impairment and who can speak on your behalf, but you must pay the cost for these other spokespersons. After the hearing you will be advised in writing of the decision of the appeal board. The decision of the appeal board is final.

The MTA is not required to provide you with paratransit service while your appeal is under consideration. If the appeal board has not made its decision within 30 days of receiving your appeal, you are entitled to paratransit service from that time until a final decision is made.

PART D. REQUEST FOR PROFESSIONAL VERIFICATION

Dear Health Care Professional:

You are being asked to complete an assessment of the applicant's disability that prevents his/her ability to use the MTA fixed routes bus system. By completing and signing this document you (the health care professional) will be certifying the truth and accuracy of the information provided on this application, to the best of your professional knowledge.

The Manchester Transit Authority's (MTA) paratransit program, StepSaver is partially funded through the Federal government. Federal Law (*The American with Disabilities Act of 1990*) requires that the MTA provide services to persons who cannot use our fixed route bus system. However, resources for StepSaver services are limited. The information you provide will allow the MTA to make an appropriate evaluation of this request for StepSaver service. To qualify for StepSaver service, a person must be unable to use fixed route bus system and fulfill the following eligibility criteria:

Individuals qualify if:

- As a result of their disability, they cannot board, ride, or deboard from a MTA fixed route bus;
- or
- They have a specific impairment related condition that prevents them from getting to or from a fixed bus route.

Please note:

- StepSaver is a transportation service for disabled persons who, as a result of their disability, cannot board, ride, or deboard from a MTA fixed route bus. **(All MTA fixed route buses are handicap accessible.)**
- StepSaver service does not include persons who find it uncomfortable or difficult to get to and from fixed route buses.
- Your verification must be filled out completely for processing to occur. **If the application is not complete it will be returned, delaying the processing of the application.**

*Your evaluation of each person must be based solely upon the individual's ability to use the MTA fixed route bus system. Please exercise care in evaluating applicants for this program. **False information used to acquire service for this applicant could result in travel limitations for other persons legitimately qualified to use this program.***

The following information will be used to ensure the appropriate type of vehicle is used to provide transportation. Feel free to call our office at any time if you have any specific questions, at 603-623-8801.

The MTA may contact the certifying Health Care Professional to verify accuracy of the information. The MTA will make the final determination as to the applicant's eligibility. Thank you for your assistance.

1. Name of applicant: _____
2. Capacity in which you know the applicant: _____
3. When was the applicant last treated or seen by you? _____
4. On average, how often is the applicant seen by you? _____
5. Please give an assessment of the applicant's functional mobility: _____

6. Please check all of the disabilities that would impair the applicant's ability to travel on the fixed route buses:

Neuromuscular:

- Cerebral Palsy
- Muscular Dystrophy
- Parkinson's Disease
- Arthritis
- Stroke/Cerebral Trauma
- Quadriplegia
- Multiple Sclerosis
- Paraplegia
- Other: _____

Cardiovascular:

- Arteriosclerosis
- Cystic Fibrosis
- Emphysema
- Congestive Heart Failure
- Chronic Obstructive Pulmonary disease
- Peripheral Vascular disease
- Thrombosis (chronic)
- Asthma
- Heart Attack
- Other: _____

Orthopedic/General Medical:

- Joint replacement (specify) _____
- Loss of limb (specify) _____
- Broken bone (specify) _____
- AIDS
- Diabetes (severe)
- Lupus
- Cancer
- Epilepsy (severe)
- Kidney disease/Dialysis
- Other: _____

Cognitive/Psychological:

- Alzheimer's disease
- Dementia
- Mental Retardation
- Phobia
- Head Trauma
- Panic disorder
- Autism
- Schizophrenia
- Other: _____

VISION		
Check all that apply	One eye	Both eyes
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Cortical Blindness	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma (all types)	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>
Retinopathy	<input type="checkbox"/>	<input type="checkbox"/>
Legally Blind	<input type="checkbox"/>	<input type="checkbox"/>
Totally Blind	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
HEARING		
Check all that apply	One ear	Both ears
Partially Deaf	<input type="checkbox"/>	<input type="checkbox"/>
Completely Deaf	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>

7. Could the applicant be left unattended at a pick-up or drop-off location?

Yes No

8. Please indicate whether the applicant can do any of the following:

Travel two blocks without assistance	Yes	No	Sometimes
Climb three 12-inch steps without assistance	Yes	No	Sometimes
Wait outside without support for 30 minutes	Yes	No	Sometimes
Give address and phone numbers upon request	Yes	No	Sometimes
Recognize a destination or landmark	Yes	No	Sometimes
Deal with unexpected situations or changes in routine	Yes	No	Sometimes
Ask for, understand, and follow directions	Yes	No	Sometimes
Travel effectively through crowded/complex facilities	Yes	No	Sometimes

9. Would the applicant's condition prevent him/her from using the public fixed route service?

Yes No

If yes, please explain in detail: _____

11. Is the applicant's condition temporary?

Yes No

If yes, expected duration is _____ months

12. Would the applicant be conditionally eligible for MTA StepSaver service due to weather conditions?

Yes No

If yes, during which months would they need service: _____

If yes, please explain: _____

13. Is there any other information about the applicant's functional ability that would be important for us to know when considering his or her ability to get to or from and use the regular fixed bus route service?

Health Care Professional's Signature: _____

Health Care Professional's Name and Title: _____

License, Registration, or Certificate Number: _____ Phone Number: _____

Company or Agency Name: _____ Fax Number: _____

Address: _____