

Date Received: \_\_\_\_\_  
 Date Entered: \_\_\_\_\_  
 Processed by: \_\_\_\_\_



Route Covered: \_\_\_\_\_  
 Paratransit Fare: \_\_\_\_\_  
 Shopper's day: \_\_\_\_\_

## Application for PARATRANSIT Service

Instructions: On pages 1 – 4 of this application, UCAT is asking for information about you and your ability to use Paratransit bus service. Please take the time to answer ALL questions carefully and completely. We cannot determine your eligibility for Paratransit service without this information. A friend, guardian, caregiver, agency service representative or family member may help you complete your portion of the application, pages 1- 4. Accurate information is required about you, your medical impairment, and your functional capacity. Pages 5 - 6 must be completed and certified by a physician/certified health professional who is familiar with your impairment or condition.

If you have questions, please call UCAT Customer Service at 845-334-8135.

Have you ever applied for Paratransit?                      No                       Yes

### TO BE COMPLETED BY APPLICANT

Name of Applicant				Does applicant have Medicaid?	
Last	First	Middle			
Address/Street		Apartment	City		Zip Code
Date of Birth	Home Phone Number		Other Phone		
Apartment Complex Name				Gate Code	
Mailing Address/If different from home address		City	State	Zip Code	
Applicant Signature (required)			Date/		
X _____			_____		

Name of Emergency Contact	Relationship	Emergency Phone

# INDIVIDUAL AND MOBILITY INFORMATION

1. Please state your disability(s).

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2. What assistive device(s) do you use when traveling? (Please check all that apply.)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Support Cane           | <input type="checkbox"/> Manual wheelchair  | <input type="checkbox"/> Trained service animal |
| <input type="checkbox"/> Crutches               | <input type="checkbox"/> Powered wheelchair | <input type="checkbox"/> Communications device  |
| <input type="checkbox"/> Walker                 | <input type="checkbox"/> Power scooter      | <input type="checkbox"/> "White cane"           |
| <input type="checkbox"/> Leg brace(s)           | <input type="checkbox"/> Portable oxygen    | <input type="checkbox"/> None                   |
| <input type="checkbox"/> Other (describe) _____ |   |   |

3. What is the nearest street intersection to your home? (Example: Polk & Wayside)

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4. Can you walk or use your wheelchair or assistive device(s) from your home to that intersection without assistance?  Yes  No

If "no," please explain.

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5. Can you find your way to a bus stop without getting lost?  Yes  No

If "no," please explain.

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6. How long can you stand and wait for a bus?

- 15 minutes  10 minutes  5 minutes  Less than 5 minutes

7. All buses have a "destination sign" in front, which shows the route name and number.

Can you read a bus destination sign? Yes  No

Can you ask the driver where the bus is going? Yes  No

Can you give or write a note to the driver? Yes  No

Can you understand the driver's answer? Yes  No

If "no" to any questions, please explain.

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8. If you were on the bus, could you pay the fare by putting money in the fare box? Yes  No   
If "no" please explain

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9. If you were on the bus, could you recognize the place where you wanted to get off the bus?  
Yes  No

If "no," please explain.

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10. Please tell us about the times when you can use UCAT's local fixed-route bus service?  
(Example: if short distance to bus stop; take attendant; need to get somewhere.)

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11. Have you ever received "orientation and mobility training "or " travel training?" Yes  No

If "yes," please list any UCAT bus routes on which you can travel:

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12. Please tell us the reasons you feel you cannot use UCAT's local fixed-route bus service for some or all trips.

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13. How do you currently travel (self, family, friends, bus, UCAT MedVan, etc.)?

Please explain.

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14. Do you require someone to travel with you? Yes  No

If "yes," please explain

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15. Can you wait independently alone at your residence and places to which you travel?

Yes  No

If "no," please explain.

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# AGREEMENT AND AUTHORIZATION:

I state that the information I have provided is true and accurate.

I authorize the release of diagnostic and functional information as requested on pages 5 and 6 to UCAT for the sole purpose of making a determination regarding my eligibility for paratransit service and understand that personal and medical information will be kept confidential.

I understand that intentionally providing false or misleading information or refusal to undergo an in-person interview assessment is grounds for denial of UCAT services.

If approved, I agree to follow the rules and guidelines established by UCAT and to promptly inform UCAT of any changes in my residence, phone number and, if applicable, my representative's name and phone number; and any significant change in my condition that would affect my level of mobility.

I understand that failure to follow proper procedures or cooperate with UCAT staff, demonstrating illegal or disruptive behavior or, if my condition at any time poses a direct threat to the health or safety of others, such situations may result in either suspension and/or termination of service.

**Applicant's Signature:**

**Date:**

\_\_\_\_\_

If someone other than the applicant is preparing this form, please provide the following information about the preparer:

Name: (please print) \_\_\_\_\_

Day Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Preparer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Return completed application:

**Email:** [ucat@co.ulster.ny.us](mailto:ucat@co.ulster.ny.us)

**Fax:** 845-334-5733 (Attention Paratransit Manager)

**Mail:** UCAT: Attn: Paratransit Manager, 1 Danny Circle, Kingston NY 12401

## Dear Physician or Healthcare Professional:

We need your assistance in determining eligibility for services provided by UCAT to persons with disabilities who are unable to use local bus transportation. We are seeking specific information as to what prevents the person from using UCAT bus routes that provide transportation throughout the area. UCAT buses are equipped with ramps, lifts, and kneeling features to assist boarding as well as automatic announcements of major stops to help riders know where they are along the route. The Americans with Disabilities Act of 1990, 49 CFR 37.121, Subpart F states– “Each public entity operating a fixed route system shall provide paratransit or other special service to individuals with disabilities that is comparable to the level of service provided to individuals without disabilities who use the fixed route system.” “By complementary, DOT means service for individuals with disabilities who cannot use the fixed route bus system.” The information requested of you in the following sections will be used to help determine the applicant’s UCAT eligibility. It is important that all questions be answered completely and accurately to the best of your knowledge and in accordance with your records. If the information is incomplete or unclear, we may need to contact you for clarification. Thank you for your cooperation.

PATIENT NAME: \_\_\_\_\_

1. Have you previously seen this patient?  Yes  No
2. Please rate (Excellent / Good / Fair / Poor / None / Don’t Know) the applicant in terms of:

	Excellent	Good	Fair	Poor	None	Don’t Know
<b>a. Upper body strength</b>						
<b>b. Lower body strength</b>						
<b>c. Coordination</b>						
<b>d. Balance</b>						
<b>e. Self-awareness</b>						
<b>f. Independent judgment</b>						
<b>g. Sense of direction</b>						
<b>h. Ability to understand and follow instructions</b>						
<b>i. Verbal communication</b>						
<b>j. Written communication</b>						
<b>k. Stamina and endurance</b>						

3. In your opinion, can the applicant travel independently from his/her house to the sidewalk?  
 Yes  No  Sometimes  
 If "no" or "sometimes," please explain. \_\_\_\_\_
4. Can the applicant walk up and down two steps?  Yes  No  Sometimes
5. Assuming the use of a mobility aid, if applicable, and with no major barriers in his/her path, how far can the applicant independently travel without assistance?  
 less than 1/4 mile  1/4 mile  1/2 mile  3/4 mile  more than 3/4 mile

6. Does the applicant's disability require him/her to travel with another person who provides personal assistance?  Yes  No  Sometimes
7. Please provide medical diagnoses in layman's terms to describe the applicant's primary impairments or disabling conditions. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
8. We are seeking specific information as to what prevents your patient from accessing the local bus and rail system. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
9. Is the condition  Permanent or  Temporary (months) \_\_\_\_\_
10. If visually impaired, what is the applicant's best corrected acuity?  
 (Snellen)? (R) \_\_\_\_\_ (L) \_\_\_\_\_  
 Field Restriction: (R) \_\_\_\_\_ (L) \_\_\_\_\_ Date of Testing: \_\_\_\_\_
11. Is the applicant a wheelchair user?  Yes  No If yes, how often \_\_\_\_\_
12. Does the applicant use other mobility aids?  Yes  No If yes, please describe.  
 \_\_\_\_\_  
 \_\_\_\_\_

**PHYSICIAN OR HEALTH CARE PROFESSIONAL'S CERTIFICATION:**

I certify that the information I have provided herein is a fair representation of this applicant's medical impairment or condition and is accurate to the best of my knowledge. I understand that the information provided herein will be used for the sole purpose of determining the applicant's eligibility for paratransit services. I also agree that UCAT may contact me for clarification of any information I have provided and that I will reply in good faith.

Physician's/Health Professional's Full Name \_\_\_\_\_

Institution/Facility/Agency Name \_\_\_\_\_

Street Address \_\_\_\_\_ Suite # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Medical/Social Worker's License Number \_\_\_\_\_ Telephone # \_\_\_\_\_ Fax # \_\_\_\_\_

Physician's/Health Professional's Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*Note: Additional signature of physician/healthcare professional on his/her letterhead or prescription verifying completion of application is required.