

ISLAND TRANSIT ADA DIAL-A-RIDE (DART) APPLICATION FOR CERTIFICATION OF ELIGIBILITY

Please complete this application as thoroughly as possible and to the best of your ability. If there are questions you do not understand, call Island Transit at (409) 797-3909 for assistance before returning this form. In order to be considered complete, every question on the application must be answered.

Each applicant is responsible for including verification for ADA service from their healthcare professional on letterhead.

INSTRUCTIONS FOR APPLYING TO ISLAND TRANSIT DIAL-A-RIDE SERVICES

ALL INFORMATION IS CONFIDENTIAL. To apply you must:

1. Complete all sections and questions of this application.
2. Have your physician or certified healthcare professional complete and sign the Application for Certification of Eligibility form.
3. Have your physician or certified healthcare professional submit an additional signature on his/her letterhead verifying completion of this application form to help us prevent fraudulent application.
4. Return the completed application with the physician or certified healthcare professional verification on letterhead to the address listed below.

***Return completed applications to:
Transportation Commission
c/o Island Transit
3115 Market Street
Galveston, Texas 77550***

If you have any questions, please call Island Transit DART at (409) 797-3909 or by fax at (409) 797-3901.

Island Transit will notify you within 21 days after receiving a complete application. Island Transit reserves the right to require additional information. Final decisions will be made by Island Transit staff. If the application is denied, the applicant has the right to appeal in writing to the above address.

BASIC INFORMATION

Name						
Date of Birth						
Phone Number	Work					
	Home					
Address						APT #
	City		ST		ZIP	

EMERGENCY CONTACT INFORMATION

Name						
Relationship						
Phone Number	Work					
	Home					
Address						APT#
	City		ST		ZIP	

INFORMATION ABOUT YOUR CURRENT ISLAND TRANSIT USE

Do you currently use Island Transit fixed-route bus service at all?	Yes	No
When was the last time you used the Island Transit fixed-route service?		
Where is the closest bus stop to your residence?		

WEATHER AND ENVIRONMENT CONSIDERATIONS

The following questions deal with how environmental factors impact your ability to use fixed-route or paratransit services.

Does the weather affect your ability to use the fixed- route service?	Always	Sometimes	Never	Don't Know
Explain				
How many steps are there at the entrance of your home?				
Can you get to the Paratransit vehicle without the assistance of another individual?			Yes	No
Please describe the terrain near your residence.				
Are there sidewalks in your neighborhood?			Yes	No

ADDITIONAL INFORMATION

Use this space to tell us anything else you would like us to know about your travel challenges and your ability to use fixed-route service.

Did you require any assistance to complete this form?					
If yes, how did he/she assist you?					
I hereby certify that all information provided is correct.					
Signature of Applicant					
Date					
If you are filling out this application for another person, fill-out the following:					
Your Name					
Relationship					
Phone Number					
Address					
	City		ST		ZIP

PART II — Please answer all of the following questions regarding YOUR mobility.

1. Are you able to board and disembark without assistance from an Island Transit Bus *without* a wheelchair lift?

Yes _____ No _____ If no, please explain: _____

2. Are you able to board and disembark without assistance from an Island Transit bus *with* a wheelchair lift?

Yes _____ No _____ If no, please explain: _____

3. Are you able to travel to the nearest bus stop?

Yes _____ No _____ If no, please explain: _____

Location: _____ How Far?: _____

4. Do you currently use Island Transit services?

a. Fixed Route Services? Yes _____ No _____

If so, what route number(s)? _____

b. Demand Response (DART) ADA Paratransit Services? Yes _____ No _____

5. Are you able to handle money and transfers?

Yes _____ No _____ If no, please explain: _____

6. Are you able to use railings and handles?

Yes _____ No _____ If no, please explain: _____

7. Are you able to keep balance while seated on a moving bus?

Yes _____ No _____

8. Are you able to understand bus schedules?

Understand and follow directions? Yes _____ No _____

Process information to ride Island Transit? Yes _____ No _____

9. If you can use a lift-equipped bus, are you presently unable to ride because:

_____ The lift cannot be operated at bus stops where you need to board?

_____ Your wheelchair cannot be accommodated on a transit vehicle?

_____ Other reasons. Please explain: _____

10. Are you prevented from traveling to or from a bus stop boarding location for one or more of the following reasons?

_____ Extreme sensitivity to climatic conditions

_____ Allergic/environmental sensitivities

_____ Hyper-fatigue, frailty

_____ Night blindness

_____ Inability to cross busy intersections

_____ Inability to climb three 10-inch steps

_____ Bus stop too far away

Please explain: _____

11. Are you able to perform the following functions without supervision?

a. Find your way between familiar locations?

Yes _____ No _____ Yes, with training _____

b. Signal the bus driver to get off at a familiar stop and get off the bus there?

Yes _____ No _____ Yes, with training _____

12. Are you able to perform the following functions without the assistance of another person?
(Y/N)

_____ Travel 300 feet (the length of a city block)

_____ Travel 900 feet (the length of three city blocks)

_____ What is the maximum distance you can travel to get to a bus stop? _____

13. Is your ability to get from place to place affected by:

_____ Terrain

_____ Rain, snow, ice

_____ Extreme temperatures of heat or very cold, windy weather

14. Are you able to wait outdoors for 15 minutes?

Yes _____ No _____ Sometimes _____

If no, please explain: _____

15. Do you have trouble standing for more than 15 minutes?

Yes _____ No _____ Sometimes _____

If no, please explain: _____

16. Does your disability allow you to use the bus when you are feeling well?

Yes _____ No _____

17. Does your disability allow you to use the bus when you are *not* feeling well?

Yes_____ No_____

18. How would you describe the terrain where you live? (Very steep incline or hill, long gradual slope)

(Incline or hill, flat, etc.)_____

19. Are you able to cross the street or a busy intersection by yourself?

Yes_____ No_____

20. Have you ever received mobility training for routes or destinations?

Yes_____ No_____

21. If travel training were available, would you be interested in participating?

Yes_____ No_____

22. List three of your most frequent destinations and how you get there?

Frequency	Destination or Street Address of Travel	How do you get there now?
_____	_____	_____
_____	_____	_____
_____	_____	_____

23. Are there places you would like to go that you *cannot* get to now?

Frequency	Destination or Street Address of Travel	How do you get there now?
_____	_____	_____
_____	_____	_____
_____	_____	_____

24. How did you find out about the Island Transit DART service? (telephone call, website, medical provider, other) _____

Information Collected for Federal Government Grant Applications

(1)The information requested below is voluntary, (2) the race and ethnic information will not affect an applicant's eligibility or level of benefits, and (3) the reason for the collection of the information is to assure that program benefits are distributed without regard to race, color, or national origin. The individual may self-identify his or her racial/ethnic status on the application. Visual observation by a program representative is used to collect the data when the individual does not self-identify. Applicant may decline to answer the following question which is asked for the purpose of federal grant applications and will not affect the applicant's eligibility for the Island Transit ADA paratransit service. Please check the designation that most accurately reflects your race/ethnicity. You may check more than one or indicate that you do not wish to provide the information:

- | | | |
|--|-----------------------------------|---|
| <input type="checkbox"/> American Indian or Alaskan Native | <input type="checkbox"/> White | <input type="checkbox"/> I do not wish to provide this information. |
| <input type="checkbox"/> Native Hawaiian or other Pacific Islander | <input type="checkbox"/> Asian | |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Hispanic | |

FOR OFFICE USE ONLY			
Date Received		Date Approved	

Expiration Date: _____

Office Use Only

Screening Committee Review:

Reviewed By: _____ Date: _____ Decision: _____

Reviewed By: _____ Date: _____ Decision: _____

Reviewed By: _____ Date: _____ Decision: _____

Comments: _____

Dear Health Care Provider:

The Americans with Disabilities Act (ADA) and its implementing federal regulations established categories of persons who are eligible to receive paratransit services complementary to fixed-route bus services. The three categories of persons with rights to complementary paratransit are:

1. Persons who, because of their disability, cannot independently board, ride and/or disembark from an accessible vehicle.
2. Persons who, because of their disability, cannot use vehicles without lifts or other accommodations.
3. Persons who, because of their disability, cannot get to or from a boarding or disembarking location.

PLEASE NOTE: Any individual is to be certified as ADA paratransit eligible if there is any part of the transit system that cannot be used or navigated by that individual because of a disability. Persons are not to be qualified or disqualified on the basis of a specific diagnosis or disability. The information requested from you on the following pages will allow Island Transit to obtain the information necessary to establish eligibility of the applicant. Thank you for your assistance.

PART V — To Be Completed By Appropriate Health Care Provider (Please Print or Type)

Please Check One: Physician Licensed Health Care Provider
 Licensed Rehab/Social Worker

Applicant's Name _____
(Last, First, Middle Initial)

Medical diagnosis of condition causing disability: _____

Is this condition permanent?
Yes _____ No _____ If not, expected duration? _____

Does the disability prevent the applicant from utilizing the fixed route services (regular bus service)? If yes, please describe in detail: _____

PART V — To be completed by an appropriate Health Care Provider

The following information will be used to ensure that an appropriate vehicle is sent to provide transportation and that Island Transit can make an accurate analysis of the applicant's trip request.

Does the applicant require any assistance of the following? (Check all that apply)

- Cane Power Chair Communication Board White Cane
 Large Power Chair Service Animal Walker Power Scooter
 Portable Oxygen Supply Crutches Manual Chair Leg Braces
 Personal Care Attendant Picture/Alphabet Board Other: _____

Please indicate below if the applicant can be left alone:

- Applicant can be left alone Applicant can't be left alone

Can the applicant walk or wheel 900 feet (3 blocks) without the assistance of another person?

Yes _____ No _____

1. Can the applicant climb three 10-inch steps with assistance?

Yes _____ No _____

2. Can the applicant wait outside without support for 15 minutes?

Yes _____ No _____

3. Is the patient on dialysis?

Yes _____ No _____

4. Does the applicant have a hearing impairment?

Yes _____ No _____

5. Is the applicant able to give addresses and phone numbers upon request?

Yes _____ No _____

6. Is the applicant able to recognize a destination or landmark?

Yes _____ No _____

7. Is the applicant able to deal with unexpected situations or unexpected changes in routine?

Yes_____ No_____

8. Is the applicant able to ask for, understand, and follow directions?

Yes_____ No_____

9. Is the applicant able to safely and effectively travel alone through crowded and/or complex facilities?

Yes_____ No_____

**** If the applicant has a visual impairment:**

Visual acuity with best correction: Right Eye_____ Left eye_____ Both eyes_____

Visual fields: Right Eye_____ Left eye_____ Both eyes_____

Please describe any other disability or effect that prevents the applicant from using the regular bus service: _____

Based upon my professional knowledge of the applicant, I certify that the preceding information is true and correct.

Name of Health Care Provider (Please Print) / Office Phone Number

Office Street Address (City, State, Zip Code)

State License Number (Complete If Applicable – Must Be Current)

Signature _____ Date _____



AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last _____ First _____ Middle _____

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (____) _____ ALT. PHONE (____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____) _____ Fax (____) _____

REASON FOR DISCLOSURE (Choose only one option below)

- Treatment/Continuing Medical Care
- Personal Use
- Billing or Claims
- Insurance
- Legal Purposes
- Disability Determination
- School
- Employment
- Other Transportation

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____ Island Transit Dial-A-Ride _____
Address _____ 3115 Market Street _____
City _____ Galveston _____ State _____ TX _____ Zip Code _____ 77550 _____
Phone (____) _____ 409-797-3909 _____ Fax (____) _____ 409-797-3901 _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> All health information | <input type="checkbox"/> History/Physical Exam | <input type="checkbox"/> Past/Present Medications | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Patient Allergies | <input type="checkbox"/> Operation Reports | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Diagnostic Test Reports | <input type="checkbox"/> EKG/Cardiology Reports |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Billing Information | <input type="checkbox"/> Radiology Reports & Images | <input checked="" type="checkbox"/> Other Diagnosis & Prognosis |

Your initials are required to release the following information:

N/A Mental Health Records (excluding psychotherapy notes)
N/A Drug, Alcohol, or Substance Abuse Records

N/A Genetic Information (including Genetic Test Results)
N/A HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____
Signature of Individual or Individual's Legally Authorized Representative _____ DATE _____

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: Parent of minor Guardian Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X _____
Signature of Minor Individual _____ DATE _____

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii)); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii)); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)).

Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.