Maritime Metro Transit's Specialized Transportation Programs

APPLICATION FOR CERTIFICATION

The attached application for specialized transportation certification is a universal application for various City and County transportation programs run by Maritime Metro Transit. Programs include:

Maritime Metro Transit's City ADA/ Paratransit Transportation: is for disabled individuals who are unable to use the fixed route public bus system***** for one or more of the following reasons: a) unable to use a fully accessible mode of transportation, b) able to use accessible transportation, but accessible transportation is not available, and/or c) there are environmental barriers (distance, terrain, weather) or architectural barriers (such as lack of curb ramps) under public control, preventing the individual from getting to or from accessible transportation. Trips must be made within a ¾ mile distance from the fixed route bus service area.

*******All buses in the Maritime Metro Transit fleet are 100% accessible with ramps and a "kneeling" feature. Maritime Metro Transit buses and ramps can safely accommodate most individuals using a mobility device up to 32" wide by 48" long and up to 600 lbs with person. The City of Manitowoc is required to provide this service under the auspices of the Americans with Disabilities Act (ADA).*

Elderly Program: is for any ambulatory person 65 years or older residing in Manitowoc County and traveling within Manitowoc County.

Rural ADA Transportation Program: Door-to-door transportation for disabled or non-ambulatory individuals with destinations or origins in rural Manitowoc County.

Please complete the following pages thoroughly and return to the address, email or fax number provided on the bottom of page 6. Applicants will receive a letter of determination within 21 days of receipt. If the applicant lives in a facility the correspondences will be sent to the facility. If the applicant doesn't live in a facility the correspondences will be sent to the applicant or the person that filled out this application depending on your request (bottom of page 5). Any incomplete applications will be returned, thereby delaying the certification process. Submission of this application does not guarantee eligibility.

The information obtained in this certification will be used only for the provision of Maritime Metro Transit's specialized services. It will not be shared with any other person or agency other than your transportation provider. Your application may be approved for full eligibility (unconditional) or on a limited basis for some trips only (conditional eligibility). *** If you reside at a skilled nursing facility and your stay is *Private Pay* certification will only be granted for a *3-month period*. Any changes in status within this 3-month certification cycle must be reported to Maritime Metro Transit immediately. Once approved, detailed information including policies, fares and service hours for the program(s) you qualify for will be mailed to you.

After reviewing your application, Maritime Metro Transit may need to:

- Contact you by phone
- Schedule a personal interview or a feasibility assessment
- Consult with your doctor or health professional
- Submit a request for professional verification to your doctor or heath professional

Personal interviews may include discussion on route travel training and/or an assessment to determine your ability to take a public transit (bus) trip. For more information, please contact Maritime Metro Transit's office at (920) 686-3560.

Section I (Must be completed by all applicants):

Please type or print:

1. Name_____Gender_____
Last First M.I.

2. Social Security Number 000-00-_____Date of Birth ___/___/_____
Last 4 digits required

3. Home Address _____City _____State_____ Zip _____

4. Email Address _____

5. Phone (home)(___) ___-_____ (work) (___) ___-_____ (mobile) (___) ___-____

Facility Name (if applicable) _____

***If you are at a skilled nursing facility which of the following two statements apply?
☐ Transportation is included in the cost of my stay ☐ My stay is Private Pay
*** If your stay is Private Pay you must re-apply every 3-months for certification. Also, any changes in status must be reported to Maritime Metro immediately.

6. Are you on Medical Assistance? ☐ Yes ***If Yes**, please provide MA ID#* ☐ No
10 digits number found on your forward health card) _____
(Otherwise known as Medicaid, Title XIX or MA-not to be confused with Medicare)

7. Are you a member of an agency such as Lakeland Care District, Community Care, DVR or IRIS
☐ Yes ***If Yes**, please check which one applies* ☐ No
☐ Lakeland Care District ☐ Community Care ☐ DVR ☐ IRIS ☐ other _____

8. Please check which best describes your current living situation:

☐ I live independently (without the assistance of another person)
☐ I live with family members who help me
☐ I receive assistance from someone that comes to my home to help with daily living activities
☐ Assisted Living Facility
☐ 24-hour care or Skilled Nursing Facility

9. Do you require the use of a mobility aid? ☐ Yes ☐ No
If Yes, please check all that apply:

☐ Manual wheelchair ☐ Electric wheelchair ☐ Electric scooter ☐ Walker
☐ Guide animal ☐ White Cane ☐ Cane ☐ Crutches

If you use a wheelchair or electric scooter, please provide the following information:

Make/Model_____ Size of device: Length_____Width_____
When you need Specialized Transportation will you be using your mobility device or will you be ambulatory (walking)? ☐ mobility device ☐ ambulatory

10. How do you currently travel to your frequent destinations? (*Check all that apply*)

☐ Drive myself ☐ City bus ☐ Paratransit
☐ Taxi ☐ Someone drives me ☐ Other, please explain _____

11. Please answer all the following questions about your mobility:
Can you travel from your residence to the curb or roadside without assistance?

☐ Yes ☐ No ☐ Sometimes

how many city blocks can you travel without the assistance of another person?

☐ 1 city block ☐ 2-4 city blocks ☐ 6-8 city blocks

Can you wait outside without support from another person for 10 minutes?

☐ Yes ☐ No ☐ Sometimes

Is your ability to travel affected by any physical, architectural, or natural barriers (such as distance, terrain, weather, lack of curb ramps, etc.)?

☐ Yes, list locations and explain_____
☐ No

12. Can you make your way to a bus stop with or without the use of a mobility device?

☐ Yes ☐ No (Check all that apply to you.)
☐ I cannot find the stop because I get confused.
☐ I need assistance when I travel to the bus stop.
☐ I cannot cross the street.
☐ Heavy rain/snow makes it impossible for me to get there.
☐ Other _____

13. Have you ever used the city bus?

☐ Yes – Why do you no longer ride the city bus?

☐ No - Why not? Please explain:

14. If personalized assistance were provided to educate you in riding the city bus, would you be able to use it? Why or why not?

15. List the names of two people who may be contacted in case of an emergency:

Name _____Relationship _____ Phone # (____)____-_____(Home)
Address _____ (____)____ -____(Mobile)

Name _____Relationship _____ Phone # (____)____-_____(Home)
Address _____ (____)____-_____(Mobile)

16. Do you have a disability or problematic health condition? ☐Yes ☐No

Section II (Please answer questions in specific detail, answers will help determine eligibility):

17. What is your disability or problematic health condition? Do not abbreviate or use acronyms.

Is this condition temporary? _____ If "Yes," the expected duration is until _____/____/_____

18. Is your disability cognitive? ☐ Yes ☐ No - If "Yes", please indicate level of assistance necessary:

☐Minimal Help ☐Moderate Help ☐Maximum Help (Must have help)

19. If you live in Manitowoc or Two Rivers, how does your disability/health condition prevent you from using the city bus? Please explain thoroughly, including any special accommodations you may need.

20. When did you first experience the condition(s) you described above?

☐0-1 year ago ☐1 – 5 years ago ☐Longer than 5 years

21. Do the conditions you described change from day to day?

☐ Yes, good on some days, bad on others ☐No, doesn't change ☐Don't know

22. Please answer the following questions about your disability/health condition:

Do you travel with a Personal Care Attendant (PCA)?

☐Yes ☐ No If "Yes," list name and relationship_____

Does your disability allow you to give addresses and telephone numbers upon request?

☐Yes ☐ No ☐Sometimes

Does your disability allow you to recognize a destination landmark?

☐Yes ☐No ☐Sometimes

Does your disability allow you to ask for, understand and follow directions?

☐Yes ☐No ☐Sometimes

Do you use a communication aide?

☐Yes ☐ No If "Yes," please specify the device_____

The Americans with Disabilities Act (ADA) now requires public transportation programs to service those individuals in a mobility device **if** the lift/ramp and vehicle can physically accommodate the passenger. If accommodations become inconsistent with legitimate safety requirements, the ADA does not guarantee your trip. This clause is observed by all specialized and non-specialized transportation services provided by Maritime Metro Transit.

To the best of my knowledge the above information is true and factual. I understand that falsification, distortion, or misrepresentation of information may result in denial of service and may lead to criminal prosecution according to appropriate federal and state law.

Signed: _____ **Date:** ___/___/ 1_____

Would you like correspondence regarding this application and service sent to you? ☐ Yes ☐ No

If this application has been completed by someone other than the person requesting certification, he/she must supply the following information about him/herself:

Name: _____Relationship: _____

Email Address _____

Address: _____Daytime phone # (____)_____-_____

Signed: _____Date: ___/___/_____

In order for your application to be evaluated, it may be necessary to contact a physician or other professional to confirm the information you have provided. Please complete the following information and authorization form:

I hereby authorize the following professional to provide the required information to Maritime Metro Transit. Furthermore, I understand that it may be necessary for me to participate in an in-person evaluation to determine my eligibility for paratransit services. This evaluation will be provided, under contract, at Maritime Metro Transit.

Signed: _____ Date: _____

Please have the following page filled out by the Medical professional that is MOST familiar with your disability/health condition and is authorized to provide Maritime Metro Transit with the information required to complete this certification.

PLEASE PRINT FULL NAME:_____**DATE OF BIRTH:**___/___/____

The following Medical professional is <u>most</u> familiar with my disability/health condition and is authorized to provide Maritime Metro Transit with the information required to complete this certification. (If more than one professional is involved with your care, please attach additional information.)

☐ Registered Nurse ☐ Rehabilitation Professional ☐ Case Manager
☐ Physical Therapist ☐ Occupational Therapist ☐ Mental Health Professional
☐ Medical Doctor

Professional(s) Name: _____Facility:_____

Address: _____City: _____ State: _____ Zip: _____

Phone #: (____)____-_____ Fax #: (____)____-_____

Dear Medical Professional,

Because the cost of providing Paratransit Services is more than ten times the cost of using our mass transit system, we need to be certain that there is a medical reason that our customers are unable to use the transit system. All of our buses are ADA compliant and equipped with ramps that allow scooters, wheelchairs and other mobility devices to ride easily. The buses also "kneel" which results in a less than eight inch step into the bus if the ramp is not used.

If you, as this applicant's Medical Professional feel there is a medical reason why he/she can't utilize our fully accessible buses, please provide a written reason for our files.

Our authorization can also be contingent upon several factors such as winter weather, time periods to allow rehabilitation, etc.

We need to carefully utilize tax dollars to ensure that we are able to provide services to those who truly need specialized transportation services.

Which statement best describes your client's condition?

☑ Being treated and is expected to improve ☐ Permanent condition that is not expected to change

Will condition interfere with independent fixed route bus usage?

☐ Yes ☐ No ☐ Sometimes (explain) _____

Professional(s) Signature: _____ Date: ___/___/____

Mail, email, or drop off this <u>completed</u> application to: Maritime Metro Transit
915 South 11th St.
Manitowoc, WI 54220
Phone: 920-686-3560
Fax: 686-5020
metro@manitowoc.org

Please note that you will be contacted via telephone if you need to be evaluated in person. All applicants will receive a letter within 21 days of receipt of the application with a determination. If you are denied, the appeals process will be provided.