PART V: APPLICANT CERTIFICATION

I understand that the purpose of this application is to determine if I am eligible for RTA's Paratransit services and that RTA staff may need to talk with 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 Paratransit service.

I agree to notify RTA if I no longer need to use Paratransit service.

______________________________ ____________________

Applicant Signature Date

OR, if applicant is unable to sign:

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

Authorized Representative Printed Name

Relationship to Applicant

Authorized Representative Signature

Date

Form: 72-987 Revised: 3/4/16

PART VI: APPLICANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize the professional listed below to release to RTA information about my disability and health condition and its effect on my ability to travel on RTA bus/rail system. I understand that I may revoke this authorization at any time.

All medical information, that you or your health care professional provides, will be kept confidential to the extent permitted under the law, except that the information may be shared with other agencies or professionals 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:

The Greater Cleveland Regional Transit Authority offers two programs for a person who has been medically diagnosed with a disability. The Fixed-Route Disability Program and Paratransit "Origin-to-Destination" Service.

Fixed-Route Disability Program: (currently $1.00 one-way)

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

- Getting on or off a standard RTA bus/rail car.
- Standing in a moving RTA bus/rail car.
- Reading information signs (legal blindness of 20/20 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/rail operator.

Paratransit "Origin-to-Destination" Service: (currently $2.25 one-way)

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

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/rail stop or station.

Federal Law requires that the Greater Cleveland Regional Transit Authority (RTA) provide Paratransit services to persons who cannot use our bus or rail transit system. The information you provide in the attached Professional Verification will allow RTA'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 Greater Cleveland Regional Transit Authority at (216) 566-5124.

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:

The following medical professional verification form must be completed by a Licensed Medical Professional or Primary Care Physician

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

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

PART VIII: MEDICAL PROFESSIONAL VERIFICATION

To be completed by your Licensed Medical Physician or Health Care Professional

PLEASE TYPE OR PRINT CLEARLY

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