# ACCESS

RTS Access paratransit is a shared ride public service intended to serve as a "safety net" for individuals who, because of their disabilities, are unable to ride the ADA compliant RTS fixed route bus for some or all their travel. A specific diagnosis or use of mobility aid does not automatically result in paratransit eligibility.

RTS Access operates within certain areas of Monroe County, NY. Please use our interactive map at **myrts.com/access** to see if your address is inside the RTS Service Area or call (585) 224-8330 option # 2**.** If you are determined eligible for paratransit service but live outside the service area, we will not pick you up or drop you off at your residence, and you will need another way to reach the pickup points inside the service area to use the service.

**How do I apply for RTS Access Paratransit Service?**

**Step 1:** In order to apply for service you must complete up through page **8** of the attached application.

**Step 2:** Once you've completed through page **8** contact the appropriate qualified treating provider and **submit the entire application to the provider** to complete part 5. In addition to completing part 5, please make sure your treating provider includes supporting documentation.

**NEW Step 3**
**Call RTS Access at (585) 224-8330 option # 2 to schedule your in-person eligibility appointment.**

**Questions about completing the application?**

Call us Monday through Friday from 8 am to 5 pm
at (585) 224-8330 option # 2

Our Promise: RTS makes it easy to enjoy your journey.

## How Is Eligibility Determined?

We do **NOT** base the decision automatically on symptoms, type of disability, use of a mobility aid, age, income, ability to drive, or access to private automobile transportation. We consider:

- Your functional ability; and
- Whether you are unable to travel on RTS fixed route service all or some of the time due to your disability; and
- Your effort and risk during such travel.

## When Can I Use RTS Access?

We will make an eligibility decision within 21 days if your application is complete at the time of your in-person eligibility appointment. If we need more than 21 days, we will notify you and give you temporary permission to use RTS Access service.

## What Else Do I Need to Know?

If your application is incomplete at your in-person eligibility appointment, it will be returned to you along with a list of what is needed to complete the application. A decision will not be made until we receive the completed application and necessary documentation.

## IMPORTANT NOTE ON COMPLETING THE APPLICATION

- Part 5 must be filled out by a licensed health care provider who treats you for the disability listed on your application and whom you authorize to release your personal health information.
- Submit the entire application to your provider after completing your section. The provider will need to review the entire application.
- Your information will be kept confidential and will not be shared with anyone outside the RTS Access eligibility process and will not be released to any other party without your written permission to the maximum extent permissible under law.
- If you or another unqualified person fills out the information for part 5, it is **FRAUD** and invalidates your application.
- If any part of the application is left blank, we will be unable to determine your eligibility.
- If your provider fails to give you supporting documentation to submit with your application, we will be unable to determine your eligibility.
- Do not mail, e-mail, or allow a medical office to send copies or documents separately to RTS.

## Part 1: PLEASE COMPLETE EACH ITEM BEFORE CALLING TO SCHEDULE YOUR IN-PERSON ELIGIBILITY APPOINTMENT

After completing each step, check the box.

| | |
|---|---|
| 1. I have reviewed the service area and I live in:<br>(please select the color based on the location of your home address)<br>☐ Green ☐ Blue ☐ Orange ☐ Gray ☐ I live in none of these | ☐ |
| 2. I provided my personal information and completed the self-assessment, pages 2-8. | ☐ |
| 3. I authorized the release of my personal health information, page 8<br>• I provided my provider(s) contact information and signed the page. | ☐ |
| 4. I had my Authorized Licensed Health Care Provider review my application, complete Part 5 and provide supporting documentation.<br>• I gave the entire application to my treating provider.<br>• My provider(s) completed pages 9-10 and returned the entire application to me.<br>• My provider(s) gave me at least one of the required supporting materials, which I attached to my application. | ☐ |
| 5. I made a copy of the application for my personal reference. | ☐ |

I understand this application is part of the process to determine eligibility for ADA paratransit service and that giving false information may result in penalties. I affirm that the information in this application is true to the best of my knowledge. I understand that I must attend my in-person eligibility appointment for RTS to determine if I am eligible for RTS Access Paratransit service.

| | |
|---|---|
| *Name of Applicant or Personal Representative* | *Signature of Applicant or Personal Representative* |

| | | |
|---|---|---|
| *Date* | *Phone Number of Applicant or Personal Representative* | *Address of Applicant or Personal Representative* |

The following Representative signed on my behalf:

☐ Parent (if applicant is a minor) ☐ Power of Attorney ☐ Legal Guardian

☐ As the Applicant, I signed on my own behalf

## Part 2: IDENTIFICATION

Date: ____________ IS THIS A RECERTIFICATION? ☐ YES ☐ NO

If "YES" write the Expiration Date and Access ID # ____________ ____________

*Expiration Date* *Access ID#*

Name: ____________

Phone Numbers: ____________

*Home Phone* *Mobile Phone*

Date of Birth: ____________ E-mail: ____________

Address: ____________

Apt/Unit: ____________

City, State, Zip: ____________

*City* *State* *Zip Code*

Provide information for the person we should contact in an emergency.

Emergency Contact Name: ____________

Relationship to Applicant: ____________

Phone Number(s): ____________

1. Due to my disability, I require information in an alternate format.

☐ No ☐ Yes ____________

*If yes, write the format here.*

2. Where should we send future information?

☐ To me, the Applicant ☐ To the Designee listed below

Name of Information Designee: ____________

Mailing Address: ____________

Email of Designee: ____________

**Part 3: SELF-ASSESSMENT**

Using fixed route service (regular RTS buses) does not automatically exclude you from paratransit eligibility.

1. I have the following diagnosed disability/disabilities:
   (Do NOT list symptoms or mobility devices. List the name of your diagnosed disability/ disabilities.)

2. I am unable to use regular RTS buses all or some of the time without the assistance of another individual because:

3. My condition: **(mark all that apply)**

   ☐ Is Constant ☐ Changes Daily ☐ Changes at Different Times of Day
   ☐ Is in Remission ☐ Not Applicable

4. I use the following assistive devices all or some of the time: **(mark all that apply)**

   ☐ Cane
   ☐ Crutches
   ☐ Walker
   ☐ Prosthesis
   ☐ Portable oxygen or respirator
   ☐ Manual wheelchair
   ☐ Motorized wheelchair or scooter
   ☐ Extra wide or heavy-duty wheelchair (24 to 34 inches wide)
   ☐ Not applicable
   ☐ Other answer:

5. I use the following to assist me some or all the time:

- ☐ Personal Care Attendant
- ☐ Service Animal
- ☐ N/A

6. I am **ABLE** to do this activity all or some of the time: **(mark all that apply)**

- ☐ Get to the RTS bus stop
- ☐ Wait alone at the RTS bus stop or curb
- ☐ Board the RTS bus
- ☐ Travel alone from a drop-off point to my destination
- ☐ Transfer from one RTS bus to another
- ☐ Ride the RTS bus
- ☐ Exit the RTS bus
- ☐ Navigate the RTS bus system
- ☐ Navigate the RTS Transit Center
- ☐ Find my way (visually / cognitively)
- ☐ Sign my name
- ☐ Use a phone to call for assistance
- ☐ Give addresses upon request
- ☐ Give phone numbers upon request
- ☐ Travel alone as a passenger
- ☐ Count money to pay for a purchase
- ☐ Insert bills, coins, or cards into a machine
- ☐ Recognize a destination or landmark
- ☐ Ask for and follow oral instructions
- ☐ Ask for and follow written instructions
- ☐ None of the choices apply to me

7. I am **ABLE** to navigate this situation all or some of the time: **(mark all that apply)**

- ☐ Unpaved areas or paths
- ☐ Places without curb cuts
- ☐ Steep sidewalks or streets
- ☐ RTS bus stops
- ☐ Snow on sidewalks or streets
- ☐ Busy streets and intersections
- ☐ None of the choices apply to me

8. My ability to cross streets is as follows: **(mark all that apply)**

| | Yes with Help | Yes on My Own | Sometimes on My Own | No |
|---|---|---|---|---|
| I can cross a 2-lane street | ☐ | ☐ | ☐ | ☐ |
| I can cross a 4-lane highway with traffic lights | ☐ | ☐ | ☐ | ☐ |

9. I use these modes of transport regularly: **(mark all that apply)**

- ☐ Personal vehicle (car)
- ☐ Public transit (RTS Connect or RTS OnDemand)
- ☐ Ambulance
- ☐ Friend/relative gives me a ride
- ☐ Sponsored ride from:

*Name of agency*

- ☐ Wheelchair or scooter
- ☐ Walking (with or without a mobility-aid)
- ☐ I do not use other modes of transport regularly
- ☐ Other answer:

a) If you marked "Wheelchair or scooter," provide these details. Otherwise, mark "Not Applicable." ☐ Not Applicable

| | |
|---|---|
| *My Weight in Pounds* | *Device Weight in Pounds* |
| *Make and Model* | *Weight Capacity* |
| *Overall Width in Inches* | *Overall Length in Inches* |
| *Battery Life (Minutes) or Battery Type* | *Maximum Driving Range in Miles* |

10. I can travel these distances on my own: **(mark all that apply)**

| | Walking **WITHOUT** mobility device | Walking with a mobility device | Using a wheelchair or scooter | Not at All |
|---|---|---|---|---|
| To/from the bus stop nearest to my residence | ☐ | ☐ | ☐ | ☐ |
| To the curb only | ☐ | ☐ | ☐ | ☐ |
| 1 block | ☐ | ☐ | ☐ | ☐ |
| 3 blocks (1/4 mile) | ☐ | ☐ | ☐ | ☐ |
| 6 blocks (1/2 mile) | ☐ | ☐ | ☐ | ☐ |
| 9 blocks (3/4 mile) | ☐ | ☐ | ☐ | ☐ |

11. The following weather conditions will affect my answers to question #8: **(mark all that apply)**

☐ Snow accumulation of 2 inches+
☐ Rainfall of ½ inch+ per hour
☐ Sustained wind speeds of 25 miles+ per hour
☐ Ice
☐ Temperature above 80°F
☐ Temperature below 30°F
☐ Not applicable

12. I can reasonably travel this distance under optimal conditions in an accessible area on my own:

_______________________________________________

*Distance in Feet, Blocks, or Miles*

## Part 4: AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

_______________________________________________

***Print Applicant's Name and Date of Birth Here***

I authorize the provider(s) named here, his/her officers, employees, agents, contractors, members, directors, shareholders, or affiliates entrusted with handling medical records, to disclose to RTS Access all the protected health information relating to me that is reasonably necessary for the provider to fully and accurately complete Part 5 of this application.

Name of Provider: _______________________________

Office or Facility Address: _______________________________

Office Phone: _______________________________

This authorization shall remain in effect until my eligibility for RTS paratransit service is finally determined or 60 days from the date of the authorization, whichever occurs first. I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the persons named above. I understand that the revocation of this authorization is not effective to the extent that the named provider has relied upon it for the use or disclosure of the Protected Health Information prior to receiving my written revocation notice.

I understand that any Protected Health Information disclosed pursuant to this Authorization to an individual or entity that is not covered by state and federal privacy laws and regulations may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I acknowledge that the named persons will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I sign this Authorization.

| ____________________ | ____________________ | __________ |
|---|---|---|
| *Printed Name* | *Signature* | *Date* |

The following Representative signed on my behalf:

☐ Parent (if applicant is a minor) ☐ Power of Attorney ☐ Legal Guardian

☐ As the Applicant, I signed on my own behalf

## Part 5: HEALTH CARE PROVIDER ASSESSMENT AND VERIFICATION

**ATTENTION APPLICANTS: AFTER COMPLETING PARTS 1-4 GIVE THE ENTIRE APPLICATION TO YOUR PROVIDER. YOU, OR YOUR REPRESENTATIVE, ARE RESPONSIBLE FOR GETTING THE APPLICATION TO THE PROVIDER AND COLLECTING THE COMPLETED APPLICATION AND SUPPORTING MATERIAL.**

**Attention Medical Professionals and Disability Service Providers:**

**A licensed or certified professional who is qualified to render specific diagnoses and assessments must complete this Part 5.**

- The Applicant must be your current patient or client.
- The Applicant must provide authorization for you to release his/her Protected Health Information (Part 4) and must give you the entire application (Parts 1-5).
- Failure to provide the information in this Part will prevent or delay processing of the patient/client's application for eligibility certification. Please pay special attention to # 6 on pg. 10 and provide your patient with supporting documentation to submit with their application.
- The following are **not** qualifying factors for paratransit service: age, income, convenience of the service, fear of falling, fear of crowds, fear of crime, fear of darkness, inability to drive, or inability to carry packages. Paratransit eligibility is based on whether a person, due to his/her disability, is unable to use the regular ADA compliant and accessible RTS system (fixed route and on-demand).

**Do not detach any part of the application. Return the entire application and materials to the patient/client or representative (parent, legal guardian, power of attorney).**

**All Protected Health Information will be kept confidential. Call 585-654-0608 if you have questions.**

1. I am a New York State licensed:
   (check all that apply)

   - ☐ Medical Doctor (MD or DO)
   - ☐ Psychologist (Ph. D.)
   - ☐ Psychiatrist (MD or DO)
   - ☐ Licensed Mental Health Professional
   - ☐ MDS Nurse (Skilled Nursing Facilities Only)
   - ☐ Nurse Practitioner (ARNP)
   - ☐ Physician's Assistant
   - ☐ Optometrist or Ophthalmologist
   - ☐ Physical or Occupational Therapist
   - ☐ Certified Orientation & Mobility Specialist

2. Licensed Professional Identification (please print clearly):

   Name: ______________________________

   License #: ______________________________
   *New York State Certification Number or License Number*

   Contact: ______________________________
   *Phone Number* *Business Address* *Email*

3. Patient/Client Identification (please print clearly)

   *Name:* ______________________ *Date of Birth:* ______________

4. List the condition that would prevent the Patient/Client from independently getting to or from or riding on an accessible RTS vehicle with equipment such as a ramp, kneeler, or lift. One diagnosis is required, but additional fields are available.

| **#1–Diagnosis/Condition (not symptoms)** | **Degree (mark all that apply)** | | **Status (mark all that apply)** |
|---|---|---|---|
| | ☐ Mild | ☐ Episodic | ☐ Active |
| | ☐ Moderate | ☐ Permanent | ☐ In Remission |
| | ☐ Severe | ☐ Temporary | ☐ Controlled w/ Medication |

| **#2–Diagnosis/Condition (not symptoms)** | **Degree (mark all that apply)** | | **Status (mark all that apply)** |
|---|---|---|---|
| | ☐ Mild | ☐ Episodic | ☐ Active |
| | ☐ Moderate | ☐ Permanent | ☐ In Remission |
| | ☐ Severe | ☐ Temporary | ☐ Controlled w/ Medication |

| **#3–Diagnosis/Condition (not symptoms)** | **Degree (mark all that apply)** | | **Status (mark all that apply)** |
|---|---|---|---|
| | ☐ Mild | ☐ Episodic | ☐ Active |
| | ☐ Moderate | ☐ Permanent | ☐ In Remission |
| | ☐ Severe | ☐ Temporary | ☐ Controlled w/ Medication |

5. I have read Part 3 and agree with the Patient/Client's self-assessment.
   ☐ Yes ☐ No ☐ Somewhat

   If **No** or **Somewhat**, explain below:

6. I am providing the Patient/Client with this material to submit with his/her Application as required by RTS Access (provide at least *one* of the following items; mark each that you provided).

| **Physical Mobility** | **Cognitive, Mental Health, or Neurological** | **Sensory Measure** |
|---|---|---|
| ☐ Active Problem List & Current Meds. | ☐ Current Clinical Assessment | ☐ Visual acuity |
| ☐ Current Patient Care plan | ☐ Current Mental Health Treatment Plan | ☐ Hearing acuity |
| ☐ Current Therapy plan (PT or OT) | ☐ Most recent Psychological Evaluation with IQ and Adaptive Functioning Score | |

7. My signature attests to the following:
   - I am certified or licensed in New York State as a disability service provider or medical professional.
   - The patient/client is currently under my care and I am authorized to release his/her Protected Health Information to degree relevant for this eligibility application.
   - I understand that the information I provide is necessary to corroborate a patient/client's application for eligibility for paratransit service under the "Americans With Disabilities Act of 1990 "(ADA) and its regulations, Section 37.123(e), within the designated paratransit service areas of RTS.
   - My statements are true and based on legitimate records, diagnosis, and assessment.

| *Printed Name* | *Signature* | *Date* |
|---|---|---|