RTS ACCESS

If you are unable to travel on an RTS fixed route bus service due to a disability, you may be eligible to use RTS Access, a paratransit bus service, within certain areas of Monroe County, NY. This allows you to schedule the specific bus rides you need instead of following a fixed route bus schedule and also allows you share a bus ride with other people who are traveling to a similar location and time.

How do I know if I am eligible and how do I apply?

Step 1: Please read the entire page one (1) to ensure you are eligible to apply for paratransit bus services with RTS Access and read the instructions on how to complete the application process.

Step 2: Please read page two (2) completely and ensure that you complete each step outlined in the checklist. RTS Access will only accept applications that are completed in full.

Once we receive the fully completed application, we will notify you within 21 business days. We thank you for your patience and hope you enjoy the ride.

Questions about completing the application?

Please fill out an online form at myRTS.com/contact-us or call us Monday through Friday from 8 am to 5 pm at 585-224-8330, Option # 2.

Application for Paratransit Eligibility Certification

What is Paratransit?
RTS Access provides public transportation for people with disabilities who are unable to use the fixed route RTS buses in Monroe County. If you are eligible, you will:

- Reserve the trips you need instead of following a fixed bus schedule; and
- Share the bus ride with other people who reserved the same trip.

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 need to determine your eligibility **BEFORE** you can use RTS Access. You cannot use RTS Access during the application process.
We will try our best to make a decision within 21 days of receiving your **ENTIRE COMPLETED APPLICATION**. 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?
We must receive the **ENTIRE COMPLETED APPLICATION** before we will process it.
Use the Part 1 Checklist to ensure that your application is completed properly.

DO NOT ALLOW A DOCTOR'S OFFICE TO FAX SECTIONS TO US. WE NO LONGER ACCEPT FAXED APPLICATIONS.

The application process:

- Is necessary to assess your eligibility;
- Does not guarantee that you will be certified eligible; and
- Often includes an interview and/or functional assessment.

After we complete the process, we will send a letter confirming or denying your application for certification.
If you feel the decision is incorrect, you can file an appeal within 60 days.

IMPORTANT NOTE ON PART 5

- This part must be filled out by a licensed health care provider whom you authorize to release your personal health information.
- 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, it is **FRAUD** and invalidates your application.
- If you skip any part, we will be unable to determine your eligibility.
- Do not allow a medical office to send copies or documents separately to RTS.

How Do I Submit My Application?
Send the entire, complete application to RTS Paratransit Eligibility through one of the following methods.

U.S. Postal Service	Electronic Mail	In Person
1372 East Main Street Rochester, NY 14609	access@myrts.com	Front Lobby 1372 East Main Street Rochester, NY 14609

Application for Paratransit Eligibility Certification

Part 1: CHECKLIST

After completing each step, check the box and write your initials.

1. **Confirm If I Live In the Service Area**
   I dialed **585-224-8330, Option #3** to learn whether my address is inside or outside the RTS Service Area. I understand that if I am eligible for paratransit service but live outside the service area, I will need another way to reach the pick-up points inside the service area, my trips must be within the service area, and I will need another way to travel from an RTS Access drop-off point to my final destination.
   ☐ _____ Initials
   ☐ Inside service area
   ☐ Outside service area

2. **Provide My Personal Information and Complete the Self-Assessment, pages 3 - 6**
   - I provided my current contact information.
   - I answered all the questions about my ability or inability to use the regular RTS buses ("fixed route buses").

   ☐ _____ Initials

3. **Authorize the Release of My Personal Health Information, page 7**
   I provided the contact information for my licensed health care provider(s) and signed the authorization.
   ☐ _____ Initials

4. **Ask My Authorized Licensed Health Care Provider to Complete the Assessment and Provide Materials. Pages 8 - 9**
   - My authorized licensed health care provider(s) completed the assessment and returned all pages to me.
   - My authorized licensed health care provider(s) gave me at least one of the required supporting materials, which I attached to my application.

   ☐ _____ Initials

5. **Recent Photo of Myself**
   Sending a photo may expedite the creation of a photo ID if you are certified eligible. If you email the photo, put your full name in the subject line.
   ☐ I attached my photo to the application with a paperclip.
   ☐ I emailed my photo to access@myrts.com (full name in the subject line).
   ☐ I prefer to come to the RTS location to have my photo taken.
   ☐ _____ Initials

6. **Review the Application, pages 3 - 9**
   - I made sure all questions have answers and all portions needing a signature are signed by the correct person.
   - I attached the materials from my authorized licensed health care provider.

   ☐ _____ Initials

7. **Make a Copy for My Records of pages 1 - 9**
   I copied my completed application for my personal reference.
   ☐ _____ Initials

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 RTS will process my application in the date order received and that my application must be complete or it will be returned to me.

_____ *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*)

My preferred phone number is: ☐ Home ☐ Mobile ☐ No Preference

Email: _____

Date of Birth: _____

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. In what format would you like to receive information from RTS Access?
   ☐ Large Font ☐ Audio Tape ☐ Email ☐ Braille ☐ Other answer:

   _____

2. Where should we send future information? ☐ To me, the Applicant ☐ To the Designee listed below

   Name of Information Designee: _____

   Address of Information Designee: _____

   Email of Information 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 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

5. I use the following mobility aids all or some of the time: (mark all that apply)

- ☐ Cane
- ☐ Crutches
- ☐ Walker
- ☐ Prosthesis
- ☐ Manual Wheelchair
- ☐ Motorized Wheelchair or Scooter
- ☐ Not Applicable
- ☐ Other answer:

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

- ☐ Unpaved 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

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

- ☐ I do not use other modes of transport regularly
- ☐ Ambulance
- ☐ Friend/relative gives me a ride
- ☐ Agency-sponsored ride from:
- ☐ Personal vehicle (car)
- ☐ Walking (with or without a mobility aid)
- ☐ Wheelchair or scooter
- ☐ Other answer:

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

My Weight in Pounds	*My Wheelchair/Scooter's Weight in Pounds*	☐ Not Applicable
Make and Model	*Weight Limit*	☐ Not Applicable
Battery Life (Minutes)	*Maximum Distance in Miles*	☐ Not Applicable

8. I can travel these distances on my own in **MILD** weather:
(mark all that apply)

	Walking **WITHOUT** mobility device	Walking with a mobility device	Using a Manual Wheelchair	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)	☐	☐	☐	☐

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

☐ Not applicable
☐ 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
☐ Other answer:

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

Distance in Feet, Blocks, or Miles

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

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

12. I use the following some or all of the time:
☐ Personal Care Attendant designated to assist me with one or more life activities regularly
☐ Service Animal trained to assist me
☐ Not applicable

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 of the protected health information relating to me that is reasonably necessary for the provider to fully and accurately complete Part 5 of this application.

-1- Name of Provider: _____

Office or Facility Address: _____

Office Phone : _____

-2- Name of Provider: _____

Office or Facility Address: _____

Office Phone : _____

-3- 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 name 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: A LICENSED \CERTIFIED PROFESSIONAL OR DISABILITY SERVICE PROVIDER WHO IS QUALIFIED TO RENDER THE SPECIFIC DIAGNOSES AND ASSESSMENTS MUST COMPLETE THIS PART. YOU, OR YOUR REPRESENTATIVE, ARE RESPONSIBLE FOR GETTING THE APPLICATION TO THE PROVIDER/PROFESSIONAL AND COLLECTING THE COMPLETED APPLICATION AND SUPPORTING MATERIAL.

Attention Medical Professionals and Disability Service Providers:

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).

Your patient/client is applying for eligibility certification to use the tax-supported paratransit service through RTS Access. Paratransit eligibility is based on whether a person, due to his/her disability, is unable to use the regular ADA compliant and accessible RTS bus system (fixed route) which provides public transportation to residents in the Monroe County service area.

Failure to provide the information in this Part will prevent or delay processing of the patient/client's application for eligibility certification.

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.

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).

Do not fax copies or materials to RTS. Faxes are no longer accepted for eligibility applications.

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)	☐ Nurse Practitioner (ARNP)
☐ Psychologist (Ph. D.)	☐ Physician's Assistant
☐ Psychiatrist (MD or DO)	☐ Optometrist or Ophthalmologist
☐ Licensed Mental Health Professional	☐ Physical or Occupational Therapist
☐ MDS Nurse (Skilled Nursing Facilities Only)	☐ 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 bus equipped with a ramp and kneeler. 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
☐ Current Patient Care plan	☐ Current Clinical Assessment	☐ Visual acuity
☐ Current Therapy plan (PT or OT)	☐ Current GAF score	☐ Hearing acuity
	☐ Current Adaptive Functioning score	
	☐ Current IQ 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*