

City of Anderson Transportation System
Application for Nifty Lift
Paratransit Service

530 Dale Keith Jones Rd. / Anderson, Indiana 46011
Phone (765) 648-6402 / FAX (765) 648-6404
E-mail: catsd@cityofanderson.com

The Nifty Lift service is a Paratransit service which is intended for use by individuals with a mental or physical impairment / disability that prevents them from using the regular fixed route bus system. In order to be eligible for Nifty Lift, you must meet certain criteria as established by the Americans with Disabilities Act (ADA), understanding that age, discomfort, occasional pain or distance to the nearest bus stop, by themselves, do not constitute an ADA eligible disability.

This application has two (2) parts: Part One (1) of this application is to be filled out by the applicant, along with a Healthcare Professional Authorization Release Form.

Please read the following carefully: **Part Two (2) of this application is to be filled out & signed by a professional** that is familiar with your transit related limitations or health related condition: such as the following; Licensed Physician, Licensed Nurse Practitioner, State Licensed or Nationally Certified Health / Rehabilitation Professional.

Please keep both parts of the application together as we will need both Parts One (1) and Two (2) for the determination of eligibility.

Eligibility Determination Process can be a 21 day process upon submission of a complete & legible application. If a determination of eligibility is not by day 21 you may have presumptive eligibility for services from that time until a final determination is made.

Note: Illegible or incomplete applications will not be processed.

Once Part One (1) is filled out by the applicant and Part Two (2) by the Professional, they will need to be returned to the following address for processing:

City of Anderson Transportation System
Attn: Nifty Lift
530 Dale Keith Jones Rd.
Anderson, IN 46011

Part One (1)

To be completed by the Applicant

Name: _____ Date: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Telephone: _____

Primary Language: _____ Male o Female o

Emergency Contact: _____ Telephone: _____

Do you use any of the following? (Check all that apply)

Manual Wheelchair: ____ Electric Wheelchair: ____ Sport Wheelchair: _____

Power Scooter: ____ Walker: ____ Cane: ____ Crutches: _____

Prosthesis: ____ Service Animal: ____ Other: _____

If you use a Wheelchair / Scooter is it? (Check all that apply)

Collapsible: ____ Wider than 32 Inches: ____ Longer than 52 inches: _____

Is the combined weight of you and the mobility device over 800lbs? Yes ____ No ____

Are you able to transfer to a seat? Yes ____ No _____

Do you require a Personal Care Attendant (PCA) when traveling? Yes ____ No _____

If you travel with a PCA does this person assist you with:

Getting to or from bus stops? Yes____ No _____

Getting on or off the bus? Yes____ No_____

Assist you at your pickup and destination? Yes____ No____

Can you be left unattended? Yes ____ No _____

Can you independently travel from your home to the nearest bus stop? Yes ___ No ___

If you answered no to the above question, please identify which barriers prevent you from having access:

Curb or uneven surface: ___ Hill: ___ Night Blindness: _____

Light Sensitive: _____ Inclement Weather: _____ Intersections: _____

Bus stop not accessible: _____ Other: (explain) _____

How does your disability affect your use of the fixed route bus system?

Do you require information you receive to be in an alternate format? Yes ___ No _____

If yes, which of the following would you need?

Braille: _____ Large Print: _____ Audio Cassette: _____ Other: _____

Did you complete this application by yourself? Yes: _____ No: _____

Applicant Signature: _____

If you answered no to the last question please fill out the following.

Name of person who assisted you: _____

Their relationship to you: _____

Their telephone number: _____

City of Anderson Transportation Evaluation for Nifty Lift

Healthcare Professional Authorization Release Form

I hereby authorize _____ **to**
(Medical Professional's Name)

release to the City of Anderson Transportation System / Nifty Lift, the necessary information about my functional limitation(s) and/or health related condition(s) that affects my ability to use Public Transit. This information combined with my submitted application will be used to determine the type(s) of public transportation programs for which I am eligible.

(Print Name of Licensed Physician, Licensed Nurse Practitioner, State Licensed or Nationally Certified Health / Rehabilitation Professional that is familiar with your transit related limitations or health related condition.)

Please print or type the following information.

Professionals Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ FAX Number: _____

All released information will be kept confidential and used only for the purpose of evaluating your transit eligibility.

Applicant's Signature _____

Print Applicant's Name _____

Date _____ **Telephone** _____

If anyone other than applicant, please fill in your name and relationship to applicant.

Dear Health Care Professional:

Federal Law requires that the City of Anderson Transportation System (C.A.T.S.) provide Paratransit services to persons who cannot use fixed route transit service. The information you provide in the attached Professional Verification will allow C.A.T.S. to make an appropriate evaluation of the applicant's transit capabilities. ***Please provide complete and specific information to describe how the applicant's functional abilities prevent them from using C.A.T.S. fixed route bus service and how the diagnosis impacts that ability, or inability.*** In the event you must disclose protected health information about the applicant, we have provided the applicant with an Authorization to Disclose Protected Health Information and asked them to include a copy with this letter.

In accordance with the "Americans with Disabilities Act of 1990" ADA and its regulations, Section 37-123(e), there are specific categories under which a person would be considered ADA eligible for Paratransit service:

"Any individual with a disability who is unable, as the result of a physical or mental impairment (including a vision impairment), and without the assistance of another individual (except the operator of a wheelchair lift or other boarding assistance device), to board, ride, or disembark from any vehicle on the system which is readily accessible to and usable by individuals with disabilities." [37.123(e) (1)]

"Any individual with a disability who has a specific impairment-related condition which prevents such individual from traveling to a boarding location or from a disembarking location on such system." [37.123(e) (3)]

"The specific impairment-related condition must prevent the person from using the fixed route system. Age, discomfort, occasional pain or distance which makes getting to or from stops/stations more difficult does not confer eligibility. A determination of whether travel is difficult rather than "prevented" will need to be made." [37.123 (e) (3)]

"For anyone, going to a bus stop and waiting for a bus is more difficult and less comfortable than waiting for a vehicle at one's home. This is likely to be all the more true for an individual with a disability. But for many persons with disabilities, in many circumstances, getting to a bus stop is possible. If an impairment-related condition only makes the job of accessing transit more difficult than it might otherwise be, but does not prevent the travel, then the person is not eligible." [37.123 (e) (3)]

PLEASE NOTE: All of C.A.T.S. fixed route buses and Nifty Lift vehicles are equipped with ADA certified Passenger / Wheelchair lifts.

Your evaluation of each person must be based solely upon the individual's ability or inability to use regular transit service. Your verification should consider only the presence of disabling condition, not the applicant's age. Please exercise care in evaluating applicants for this service. False verification could result in travel limitation for persons legitimately qualified to use Paratransit. If you have any questions about the Application or the review process, please contact Nifty Lift at (765) 648-6403.

Nifty Lift staff is available to train or assist your office personnel in the handling of these applications.

Sincerely,
Merle Jones,
General Manager

This part is to be completed by Medical Professional

Physical Impairment

Applicants Name: _____

Does the applicant Impairment / Disability prevent them from?

Riding ADA compliant fixed route buses? Yes _____ No _____

Traveling 200 feet without assistance? Yes _____ No _____

Climbing three (3) twelve (12) inch steps? Yes _____ No _____

Waiting outside without support for ten (10) minutes? Yes _____ No _____

Does the applicant have difficulty breathing? Yes _____ No _____

Can the applicant travel alone, without an attendant? Yes _____ No _____

Is the applicant a danger to themselves or others? Yes _____ No _____

Is the applicant Impairment / Disability Permanent? Yes _____ No _____

Is the Impairment / Disability Temporary? Yes _____ No _____

If it is Temporary can you give an approximate date of when they may resume normal activities? Month _____ Year _____

Please describe in layman's terms any other Physical disability that we should be aware of:

Cognitive Impairment

Applicants Name _____

If this person has a cognitive disability are they able to:

Tell Time? Yes _____ No _____

Recognize Numbers? Yes _____ No _____

Safely and effectively travel alone? Yes _____ No _____

Understand and follow directions? Yes _____ No _____

Recognize a destination or landmark? Yes _____ No _____

Deal with unexpected situations or routine? Yes _____ No _____

Give address and phone number if requested? Yes _____ No _____

Function without danger to themselves or others? Yes _____ No _____

Please describe in layman's terms any other mental disability we should be aware of:

I hereby certify that in my professional judgment, the information provided in this application to be correct.

Professional Name: _____ Date: _____

Title: _____ Phone: _____

Address: _____

Signature: _____