Application for Vista Transit Curbside Service

(Eligibility for Mobility Limited Riders Not Able to Use Fixed Route Service)

Part I: **Applicant Information** Applicant's Name and Address (please print)

Last Name:________________________________ Date of Birth:____________________

First Name:________________________________ Middle Initial:____________________

Address:__________________________________ Apt. #/Unit:______________________

City:______________________________State:_______ Zip Code:______________________

Telephone Number:_________________________ Email:________________________________

Return this completed application including:

Part I	Applicant Information	(Page 1)
Part II	Information Release Form	(Page 2)
Part III	Professional Verification	(Pages 3 & 4)
Part IV	Personal Care Attendant	(Page 5)

Upon completion of this application, please return to:
Vista Transit
401 Giulio Cesare Ave.
Sierra Vista, AZ 86535

THERE IS A* $5.00 *SERVICE CHARGE FOR PROCESSING ALL APPLICATIONS

If you have any questions please call the Vista Transit Office at 520-417-4888.

Application for Vista Transit Curbside Service Eligibility:
(To be completed by Vista Transit Staff)

☐ Approved and Issued Date:_______________________________

☐ Partial service ☐ Full service

☐ Not Approved Reason:_______________________________________

☐ Appeal Process Information Provided Date:______________________

By: ____

Application for Vista Transit Curbside Service

(Eligibility for Mobility Limited Riders Not Able to Use Fixed Route Service)

Part II Information Release Form

Applicant's Name and Address (please print)

Last Name:___________________________ Date of Birth:________________________

First Name:___________________________ Middle Initial:_______________________

Telephone Number:____________________ Email:______________________________

In order for Vista Transit to evaluate your request, it may be necessary to contact you directly, or your health care professional to confirm the information you provide or to answer any additional questions.

The following health care professional is familiar with my disability and functional abilities and is authorized to provide the required information to Vista Transit. In the space provided below, please provide the name and information of a professional that is familiar with your abilities.

Name:____
First MI Last

Address:____

____
City State ZIP

Phone:____ FAX:__________________________

I hereby certify that the information given in this application is correct. I understand that if my application is not found to be eligible, that I may appeal such determination within 60 calendar days and that I will be advised of the procedures for such an appeal. I hereby authorize Vista Transit to contact the professional or agency listed above to verify documentation of function abilities.

Applicants Signature or Mark:____

Date:__________________________

Witness (for mark only)_____________________________ Date:______________________________

Application for Vista Transit Curbside Service

(Eligibility for Mobility Limited Riders Not Able to Use Fixed Route Service)

Part III Professional Verification (Page 1 of 2)

Applicant's Name and Address (please print)

Last Name:_______________________________________ Date of Birth:___________________

First Name:_______________________________________ Middle Initial:__________________

Telephone Number: _______________________________ Email:_________________________

To Applicant:

Please take this section of the application to your health care professional for verification of your disability.

To: Evaluating Health Care Professional,

This patient/client has completed a paratransit application requesting curb-to-curb service from his/her home to destinations within Sierra Vista. The American with Disabilities Act is *very specific* on who qualifies for curb-to-curb transportation services as opposed to riding our fixed route system. Because of your professional relationship with this applicant, you are uniquely qualified to help clarify his or her functional abilities and limitations. The following are guidelines for using Vista Transit ADA. These guidelines may help you in understanding the type of information we need in order to determine the applicant's eligibility for Vista Transit ADA curbside service.

Can you please respond to and check the applicable following statements?

NOTE *In accordance with the Americans with Disabilities Act, a disability is a disabling condition which makes using Vista Transit fixed route buses impossible (***A-1***), accessing a Vista Transit fixed route bus stop (***A-3***) and/or boarding a Vista Transit fixed route bus (***A-2***).*

A-1 ( ) I certify that the above named individual, because of their disability, cannot **INDEPENDENTLY** board, ride, and/or disembark from any bus in the Vista Transit fixed route system.

A-2 ( ) I certify that the above named individual has a disability related condition (s) that **PREVENTS** him/her from riding Vista Transit's fixed route buses.

A-3 ( ) I certify that the above named individual has a disability related condition(s) that **PREVENTS** him/her from getting to or from a Vista Transit fixed route bus stop.

Part III Professional Verification (Page 2 of 2)

Please explain applicant's disability completely. If you checked A-1, A-2, and/or A-3, explain how it ***PREVENTS*** the applicant from riding Vista Transit in accordance with the ADA:

____

____

____

Condition is ( ) Permanent ( ) Temporary – From ____________________ to ____________________

____
Name of Certifying Person (Please print)

____
Signature

____
Title Telephone Number

____
Date Medical ID Number

Part IV Personal Assistance

Applicant's Name and Address (please print)

Last Name: ____Date of Birth:________________

Vista Transit ADA Paratransit is a curb-to-curb service. Drivers of the vehicles may not enter any structure to find you or assist you to the curb. You must be able to get to and from the curb. If you are unable to get to the curb independently, you must have a friend, relative, or home healthcare worker assist you with your mobility needs.

If you need an assistant to provide service for you in order to make travel possible, you must fill out this information to register your eligibility to travel with a personal assistant.

I certify that I need the services of a personal care attendant to make independent travel possible. A personal care attendant is someone designated or employed specifically to assist me with the completion of at least one daily activity on a regular basis.

I will need a Personal Care Attendant:

☐ Permanently ☐ Temporarily ☐ Occasionally

If temporary, provide expected duration____

I certify that the information provided is true and correct.

Applicants Signature or Mark:____

Date:__________________________

Witness (for mark only):___________________________________ Date:____________________