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	(One Page)
Part II	Information Release Form	(One Page)
Part III	Professional Verification	(Two Pages)
Part IV	Personal Care Attendant	(One Page/Only if applicable)

To:
Vista Transit
401 Giulio Cesare Ave.
Sierra Vista, AZ 86535

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:_____

☐ Not Approved Reason:_____

☐ Appeal Process Information Provided Date:_____

By: _____
Vista Transit

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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 a professional to confirm the information you provide or to answer any additional questions.

The following 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:_____

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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 a professional for verification of your disability. We suggest you take these forms to a Case Manager, Social Worker, Health Care Professional (Nurse, Physical Therapist, Rehabilitation Specialist, etc. or Physician)

Guidelines for Professional Report:

Your patient/client has requested eligibility for Vista Transit ADA transportation service. Because of your professional relationship with this applicant, you are uniquely qualified to help clarify his or her function 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.

The basis for Vista Transit's eligibility is the Americans with Disabilities Act. Eligibility is based on:

- Functional ability to independently perform the tasks necessary for bus use including: getting to and from the bus stop, getting on the bus, riding the bus, and understanding how to navigate the system in a variety of environments. A diagnosis by itself does not qualify an individual for Vista Transit ADA.
- Whether an individual is prevented from performing these tasks (as opposed to the task being more inconvenient or difficult).
- Whether the individual can perform these tasks all of the time, only under some circumstances, or if the disability would always prevent the individual from performing these tasks. Vista Transit ADA eligibility is unique to the individual persons' functional ability and reflects ability to use the bus stop only in some circumstances (example, could use the bus if it were not more than two level blocks to the bus stop, no ice present, etc.)

Please complete the attached and return to applicant or mail directly to:

Vista Transit
401 Giulio Cesare Avenue
Sierra Vista, AZ 85635

Part III Professional Verification (Page 2 of 2)

Applicant's Name and Address (please print)

Last Name:_____ Date of Birth:_____

1. Is the applicant currently your patient?

   Yes ☐ No ☐

2. Does the applicant have a functional or cognitive disability?

   Yes ☐ No ☐

   "Cannot perform tasks necessary for bus use including: getting to and from the bus stop, getting on the bus, riding the bus, and understanding how to navigate the system in a variety of environments." *Note: ADA excludes from eligibility persons whose sole incapacity is pregnancy, obesity, acute or chronic alcoholism/ drug addiction, or contagious disease.*

3. Does this patient's disability prevent them from using Vista Transit's route service safely?

   Yes ☐ No ☐

HEALTH CARE PROFESSIONAL CERTIFICATION:

In my professional judgment this applicant's disability is: (Check one only)

☐ Permanently Disabled ☐ Temporarily Disabled for _____ months.
(Note: Eligibility will not be issued for less than 3 months or more than 3 years)

Name:_____ Date:_____

Address:_____

Telephone #:_____ AZ Professional Lic. #:_____

I certify that this information is true and correct to the best of my knowledge.

Signature:_____

Please mail completed form to: Vista Transit
401 Giulio Cesare Avenue.
Sierra Vista, AZ 85635

Application for Vista Transit Curbside Service

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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:_____