



Dear Applicant:

Kootenai County's Citylink Transit, in accordance with the Americans with Disabilities Act of 1990 (ADA), provides paratransit or "origin-to-destination" service to clients with an ADA eligible, functional limitation, that prevents them from utilizing public transportation. The purpose of this application form is to determine if, or under what circumstances, the applicant can use Kootenai County's Citylink fixed route buses.

Eligibility is determined by the individual's ability to navigate the regular bus system

Operational issues are not used to determine eligibility, including:

- Age
- Distance to bus stop
- Lack of bus service to an area
- Vulnerability
- Lack of transportation

In addition, Citylink's regular bus service is accessible for all disabilities; therefore, having a disability does not by itself qualify you for Paratransit eligibility. Eligibility is not a medical decision; the decision is based only on your functional ability to use the regular bus.

**After you submit your application, you will be asked to provide additional information and to participate in an in-person assessment.** Your application will not be considered complete until all requested information is provided to Kootenai County Paratransit. Once your application is complete, we will make a determination within 21 days.

The Americans with Disabilities Act (ADA) of 1990 prohibits discrimination against people with disabilities. Upon request, alternative formats of the information will be produced for people with disabilities, if required. Please call (208) 446-1616. Call 711 for TTY services.

## Part 1: Please Fill Out All Information to the Best of Your Ability

The enclosed application must be complete. You may have someone fill it out for you if needed. **Any application containing falsified information will be denied.**

Read PART 2 completely. Sign your name in the box on page 9. A signature is required before an application can be processed. Legal guardians must sign the application, if applicable. Send your completed application to your healthcare professional and keep a copy for your records.

Have PART 3, –Licensed Medical or Mental Health Professional Verification - completed and signed by a licensed medical or mental health professional. (See list of approved professionals at the top of page 13.) Incomplete information, or information filled out by the applicant will delay the process and/or invalidate the application.

Return the completed application to the address on the form. (See the bottom of page 16.)

***Your application will not be considered complete until all requested information is provided to Kootenai County Paratransit for evaluation.***

### GENERAL INFORMATION

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ Apt#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Phone: (\_\_\_\_\_) \_\_\_\_\_ TTY: Yes No

Evening Phone: (\_\_\_\_\_) \_\_\_\_\_ TTY: Yes No

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you: Male  Female

Are you a veteran?  Yes  No

Do you need future written information provided to you in an accessible format?

Yes  No

Emergency Contact Person:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Day Phone: (\_\_\_\_\_) \_\_\_\_\_ Eve. Phone: (\_\_\_\_\_) \_\_\_\_\_

**Section A. General Information about Your Disability**

**1A.** What type, or types, of disabilities prevent you from using Kootenai County’s Citylink buses?

Please check any that may apply.

- Physical disability
- Developmental disability
- Mental illness
- Visual impairment/Blindness
- Brain injury
- Other \_\_\_\_\_

**2A.** Please describe under which types of conditions your disability, or disabilities, prevent you from riding our lift equipped Citylink buses.

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**Section B. Information for applications due to vision related disabilities/deficits.**

(If you have no vision deficit, you may skip this section)

**1B.** Cause of vision loss/ Diagnosis:

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**2B.** Are you totally blind?  Yes  No If yes, skip to question #7.

**3B.** My vision is worst during these conditions. Check all that apply:

- Bright sunlight
- Dimly lit or shaded places
- Nighttime
- I see the same in different lighting conditions

**4B.** My eye condition is considered to be:

- Stable
- Degenerative
- Other (please explain)

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**5B.** I am unable to use my vision to consistently identify the following signs and environmental features as they relate to traveling to the bus stop and using Citylink bus service. Please check any that may apply:

- The color of traffic lights
- Pedestrian Walk/ Don't Walk signals
- Crosswalk markings
- Curbs or curb ramps
- Level changes along the walking path
- Bus/transit stop signs that indicate the location of the stop

**6B.** Is there anything else you wish to tell us about your vision in regard to mobility within the community?

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**7B.** Most often, I use the following mobility aids when I walk outside: Please check any that may apply:

- Sighted (person) guide
- Guide dog
- White cane
- Optical devices (telescope, light, special glasses, etc.)
- None of the above
- Other, please list: \_\_\_\_\_

**8B.** When I'm not sure of which way to go or when to cross a street, I am able to request and understand instructions or utilize assistance.

- Yes     No     Sometimes

**9B.** My hearing is normal:  Yes     No

If No, please describe your functional hearing problems.

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**C. Information for applications due to physical related disabilities/deficits.**

**1C.** Which of the following mobility aids or equipment do you use when you travel outside your home? Check **all** that apply and indicate the **percentage of time** you use the aid (example: no aids - 10%, support cane - 90%).

- |  |  |
|--|--|
| <input type="checkbox"/> No aids ___%      | <input type="checkbox"/> Walker ___%               |
| <input type="checkbox"/> White Cane ___%   | <input type="checkbox"/> Motorized Wheelchair ___% |
| <input type="checkbox"/> Support Cane ___% | <input type="checkbox"/> Motorized Scooter ___%    |
| <input type="checkbox"/> Crutches ___%     | <input type="checkbox"/> Manual Wheelchair ___%    |

If you checked more than one box, explain when/how you use the aids:

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**2C.** Do you use a motorized wheelchair or scooter? Yes  No

**3C.** If yes, what make and model? \_\_\_\_\_

**4C.** If you use a motorized chair, identify the impediments keeping you from using the Citylink buses? \_\_\_\_\_

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**5C.** If you use a manual wheel chair, can you self propel? How far?

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**6C.** Please tell us under what conditions you believe you are limited from utilizing the Citylink buses?

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**7C.** Do you travel with portable oxygen? Yes  No

**8C.** Do you travel with a personal care assistant (PCA)? Yes  No

**9C.** How do you get to your destinations now? (Check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> By bus            | <input type="checkbox"/> Social Service Agency |
| <input type="checkbox"/> Drive myself      | <input type="checkbox"/> Walk or Use scooter   |
| <input type="checkbox"/> Someone drives me | <input type="checkbox"/> Other:                |
| <input type="checkbox"/> Taxi              | _____  |

**10C.** If the weather is good and there are no environmental barriers, how far can you travel outdoors using your mobility device, if applicable.

\_\_\_\_\_

**D. Weather and Environment**

**1D.** Are there ways you are limited from using the bus system?

Please check any that apply:

- I cannot get places if there are no curb-cuts
- I cannot cross busy streets and intersections
- I cannot travel outside when it is too hot or too cold due to my disability
- I cannot find my way at night because of a vision disability
- I get confused and cannot find my way
- I probably could with travel training

Other: \_\_\_\_\_

\_\_\_\_\_

Please use this space to tell us anything else you would like us to know about your travel challenges and your ability to utilize the regular bus system.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**E. Information about Your Current Use of Citylink Bus Services or Paratransit Services**

**1E.** Do you currently use Kootenai County’s Citylink Transit by yourself?

- Yes     No

**2E.** If yes, how often? (check the choice that best applies to you)

Daily

Several times per week

Once per month

Rarely

**3E.** When was the last time you independently used Kootenai County's Citylink Transit?

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**4E.** If you need the assistance of another person to travel while using the bus or train, what assistance does this person provide?

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**5E.** If you indicated that you do not use Citylink Transit. Why not? Please check any that may apply:

The closest stop is too far from my house

I do not know how to ride Citylink Transit

I cannot travel by myself between the bus stop and my destination

I'm afraid to use Citylink Transit

I do not want to use Citylink Transit

Other (explain)

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**6E.** Please list destinations for which you use, or need Paratransit services, and the reasons why you are unable to use Citylink bus services for those trips.

**a.** Destination and address:

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How often do you go? \_\_\_\_\_

How do you get there currently? \_\_\_\_\_

Reason unable to use Citylink bus service: \_\_\_\_\_

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**b. Destination and address:**

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How often do you go? \_\_\_\_\_

How do you get there currently? \_\_\_\_\_

Reason unable to use Citylink bus service: \_\_\_\_\_

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**c. Destination and address:**

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How often do you go? \_\_\_\_\_

How do you get there currently? \_\_\_\_\_

Reason unable to use Citylink bus service: \_\_\_\_\_

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**7E.** Please read the following statements and check any, or all, of those that best describe what you believe about your ability to use Citylink Transit by yourself.

- I use Citylink buses for some trips, but sometimes there are barriers that prevent me from using these services
- I use Citylink buses on routes to familiar destinations
- I use Citylink buses to go to new places
- I believe I could use Citylink buses if someone taught me
- I am not able to use Citylink buses by myself
- The severity of my disability changes from day to day, I ride Citylink buses when I am feeling well
- Some weather conditions prevent me from getting to and from the bus stop
- I can get to and from the bus stop if the distance is not too great
- The bus does not always go where I want to go

8E. Do you use a Service Dog?  No  Yes – What is it trained to do? \_\_\_\_\_

**Representative:**

If a person other than the applicant filled out this application, please complete the following (please print):

Name \_\_\_\_\_ Daytime Phone# \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_ Agency \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**PART 2: PARATRANSIT SERVICE APPLICANT AGREEMENT & AUTHORIZATION FOR RELEASE OF INFORMATION**

**By signing below, you authorize the release of verification information and any other information to Citylink Paratransit or its representatives needed to evaluate your eligibility to receive Paratransit service.**

Please be advised that Citylink Paratransit will use your statements to determine your eligibility for Paratransit service as provided by law. The statements contained herein are material to Citylink Paratransit's determination and Citylink Paratransit may act in reliance thereon.

Providing false information is punishable by fine or imprisonment (Idaho Code, Title 18, Sections 18-5401 and 18-5409).

Citylink Paratransit may share your eligibility determination with other transportation providers, on request, to facilitate travel in other transit districts.

Documents used by Citylink Paratransit regarding your Paratransit eligibility, with the exception of information provided by your medical professional, may be subject to public disclosure in response to a public records request. Citylink Paratransit will attempt to notify you should there be a public records request for your eligibility documents.

**This form must be signed by the Applicant or by the individual who has designated power of attorney, or is a legal guardian for the Applicant. If the Applicant is under 18 years of age, a parent or legal guardian must sign this form. If the Applicant is over 18 years old and you are signing as a power of attorney or legal guardian, please include a copy of the authorizing document.**

**"I hereby certify under the penalty of perjury under the laws of the State of Idaho that the information provided on this application is true and correct."**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Applicant  Designated Power of Attorney  Legal Guardian

**Printed Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_



Applicant's Name: \_\_\_\_\_

### **PART 3: LICENSED MEDICAL OR MENTAL HEALTH PROFESSIONAL VERIFICATION**

For the purpose of this application, licensed medical or mental health professionals are limited to the following list. ***The application may be considered invalid if this portion is filled out by the applicant.***

**Please check one:**

- |   |   |
|---|---|
| <input type="checkbox"/> Medical Doctor (MD or DO)                        | <input type="checkbox"/> Optometrist or Ophthalmologist     |
| <input type="checkbox"/> Psychologist (Ph.D.)                             | <input type="checkbox"/> Physician Assistant or ARNP        |
| <input type="checkbox"/> Licensed Mental Health Professional              | <input type="checkbox"/> Physical or Occupational Therapist |
| <input type="checkbox"/> MDS Nurse (from Skilled Nursing Facilities Only) |   |

**INSTRUCTIONS:** If the Applicant is your current patient or client, please answer the following questions. All health care information will be kept confidential.

Please note that Paratransit is a costly service and all of our Citylink public transit buses are free and equipped with wheel chair lifts. Please call (208) 446-1616 if you have any questions. **Please write legibly and fill the form out completely so a determination can be made based on this information. Any incomplete information will be returned to you for completion.**

Eligibility is determined by an:

Individual's ability to navigate the regular bus system (i.e. due to dementia)

Operational issues are not used to determine eligibility, including:

- Age
- Distance to bus stop
- Lack of bus service to an area
- Vulnerability
- Lack of transportation

1. Paratransit is a shared ride public bus service that requires people to wait at their location and destination for up to 35 minutes until the bus arrives. We do not carry items, walk people in and out of buildings, or provide personal care services. Knowing this, can your client function on a shared ride service without an escort?

No    Yes

\_\_\_\_\_

\_\_\_\_\_

2. In what ways do the client's physical or cognitive diagnoses make travel in the transit system more difficult or impossible?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

3. What kind of barriers does your client face in regard to using the transit system? Keep in mind that all buses have lifts for accessibility.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

DIAGNOSIS/DISABILITY	DEGREE OF IMPAIRMENT			DATE OF ONSET
(not symptoms or medical codes)	(circle one)			If known
	Mild	Moderate	Severe	
	Mild	Moderate	Severe	
	Mild	Moderate	Severe	
	Mild	Moderate	Severe	
	Mild	Moderate	Severe	
	Mild	Moderate	Severe	
	Mild	Moderate	Severe	
	Mild	Moderate	Severe	
	Mild	Moderate	Severe	

4. Is the Applicant's condition temporary? For instance, until healed from hip, back or knee surgery:  No  Yes – until \_\_\_\_\_

5. Are any of the applicant's conditions episodic or variable in their severity? Some examples would include fatigue from dialysis or relapsing and remitting symptoms as in MS?  No  Yes - Provide details below:

\_\_\_\_\_  
 \_\_\_\_\_

6. A majority of our applicants can use bus service for some of their trips, and all buses are lift equipped for ease of entrance, under what circumstances do you believe that your client use the bus?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

7. What form(s) of transportation is your client currently using?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. How does your patient get from the parking lot to your office?

\_\_\_\_\_

a. What aids do they use, if any?

\_\_\_\_\_

b. What is the distance your patient can ambulate in regard to your office visit?

\_\_\_\_\_

c. Does your patient require a Personal Care Assistant (PCA) for assistance?  No  Yes

9. If your client has a motorized wheelchair or scooter, what is your client's weight without the device? \_\_\_\_\_

10. If your client has a motorized wheelchair or scooter, what is the combined weight of your client and the mobility aid? \_\_\_\_\_

"I HEREBY CERTIFY under penalty of perjury under the laws of the State of Idaho that the information provided on the Professional Verification portion of this application is true and correct." Please write legibly.

\_\_\_\_\_  
Licensed Professional's Signature      Printed Name      Date      Specialty

Medical Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_

Return Application to:

Citylink Paratransit Service  
451 N. Government Way  
P.O. Box 9000  
Coeur d'Alene, ID 83816-9000  
Phone: (208) 446-1616      Fax: (208) 446-1039