Rider's Name: _____

Phone No: _____

COTA use only		
Received by:		
Date Received:		
	Approved	Disapproved
Date		
Initials		

Caller Box 10007

Saipan, MP 96950

Telephone: 670-664-2682

Fax: 670-664-2692

Email: COTA@gov.mp

Commonwealth Office of Transit Authority

Application for Eligibility of ADA Paratransit Services

June 2018

If you are 55 years of age or older, believe you have a disability, or a US Military Veteran

... *that prevents you from using regular transportation, please complete this application and return to the address above to determine your eligibility to receive*

ADA Paratransit services

COMMONWEALTH OF TRANSIT AUTHORITY

DEMAND RESPONSE
ELIGIBILITY APPLICATION

COTA Demand Response is a specialized curb-to-curb transportation service provided as required by the Americans with Disabilities Act (ADA). The ADA requires Demand Response service to be provided to people who are prevented by an impairment. The more complete and accurate the information you provide, the better COTA will understand your abilities and travel challenges.

The Federal Americans with Disabilities Act (ADA) requires comparable public transportation services for person with disabilities who are unable, because of their disability to use a regular transportation.

If you believe you have a disability that prevents you from using the regular public transportation, please complete this application and return it to the address below to determine your eligibility.

It is important that all parts of this application are completed. **You, the applicant, are responsible for the completing the entire application form.**

- COTA will review your application and follow-up as necessary to determine you eligibility for paratransit series.
- COTA will notify you within 15 days of receiving your completed application regarding your eligibility for paratransit services.

If you have not received a determination after 15 days of submitting your application, please call (670) 664-2682. If you are denied eligibility, you have a right to appeal the eligibility decision. Please contact COTA on the appeals process.

PLEASE SEND COMPLETED APPLICATIONS TO: COTA, Caller Box 10007. Saipan, MP 96950.

If you have questions regarding the eligibility application process, ADA Paratransit Service, or other transit matter, please call (670) 664 – 2682, fax 670-664-2692, send email to cnmicota@gmail.com or visit our website at www.cnmicota.wixsite.com/cota-mp

There are two sections to this application, the **Demand Response Eligibility Application** and the **Physician Verification Form.**

Here's what you need to do:

1. Complete the **Demand Response Eligibility Application** and return it by mail, fax, or in person to the COTA office at the address below. REMEMBER TO SIGN AND DATE PAGE 8, and be sure to check WHETHER OR NOT you require a personal care assistant on Page 7.

2. Sign the **Authorization Form for Disclosure of Protected Health Information**, which is part of the **Physician Verification Form** and take it and the **Physician Verification Form "PVF"** to a physician that is familiar with your functional abilities. Advise the office staff that THE PVF FORM MUST BE SIGNED BY A MEDICAL DOCTOR. The signature of a nurse or physician's assistant will not be accepted and will delay the processing of your application. The doctor's office may fax or mail the PVF to us or may return it to you.

3. The processing of your application will not begin until both parts are received signed and completed as required. Once this happens, your application will be processed and sent to administration for review. Although policy allows 15 days to process and review your application, we strive to complete the process in advance. While you are in the review process, you may utilize the service as needed. Going on the assumption that you are approved, this service would then continue uninterrupted. You will receive a call/letter regarding your eligibility for service.

You MAY be required to participate in an interview with COTA staff once we receive both completed parts of your application.

Note: A photo is ID is required to complete the processing of your application. We accept driver's license, Mayors' ID, and Passports.

If you are over the age of 65, you will automatically be approved with proof of ID. Please fill out ONLY pages 4, 7, and 12.

PLEASE NOTE THE COTA CONTACT INFORMATION:

Commonwealth Office of Transit Authority
2nd Floor, Marianas Business Plaza
Susupe, Suite. 206
Caller Box 10007
Phone: (670) 664-2690
Fax: (670) 664-2692

DEMAND RESPONSE
ELIGIBILITY APPLICATION

Name: Last _____ First _____Middle_____

Birth Date: _____ Gender: __ Female __Male

Primary Language: __ English __Other (specify_____)

Home Address: _____

City _____State_____ Zip Code_____

Mailing Address, if different than above:

City_____ State_____ Zip Code_____

Emergency Contact

Name: _____ Relationship: _____
Daytime Phone _____ Evening Phone _____ Cell Phone _____

Do you manage your own affairs and deal with your own mail? __ Yes __ No

If no, to whom should important correspondence be mailed?

Name: _____
Relationship: _____
Address _____City _____ Zip Code_____

For Office Use Only: Approved ___Denied ___ Initials: _____ Date_____
Eligibility __ Boundaries_____
PCA__ Yes __No
Date Processed: _____
Expiration Date: _____

Please answer the following questions in detail. Your specific answers to the questions will help us in determining your eligibility.

☐ First Time Applying ☐ Renewal ☐ Re-Applying

1. What functional impairment, disability, or disabling health condition do you have and how does it prevent you from using the COTA fixed route bus?

2. Do the conditions you described change from day to day in a way that affects your ability to use the fixed route bus?
__Yes, I could use fixed route on some days, but on other days I couldn't.
__No, doesn't change.
__ Don't know.

3. Are the conditions you described?
__Permanent
__Temporary
__Don't know

If temporary, how long do you expect the condition to continue?

4. Do you use any of the following mobility aids or specialized equipment?
(Circle all that apply)

_Power Wheelchair _Communication Devices _Cane _Service Animal _Walker _White Cane
_Crutches _Manual Wheelchair _Power Scooter _Portable Oxygen Tank _Leg Braces _Other Aid

5. If you use a power scooter, power wheelchair, or manual wheelchair, your use of these aids is subject to size and weight restrictions.

What are the dimensions of your mobility aid?
Width_____ Length_____
How much does your mobility aid weigh when occupied? Pounds

6. Please check the box that best describes your current living situation.
_Live independently (without the assistance of another person)
_24-hour care or Skilled Nursing Facility
_Live with family members who help me
_Assisted Living Facility
_Receive assistance with daily living activities from someone that comes to my home

7. How far can you walk or travel using the mobility aids or specialized equipment identified in Question 5 above without the help of another person?
_Less than 1 block
_Up to 2 blocks
_3 to 6 blocks
_7 or more blocks

8. Which of the following statements best describes you if you had to wait outside for a ride? *(Check only one response)*
__I could wait by myself for 10 to 15 minutes.
__I could wait by myself for 10 to 15 minutes only if I had a seat and shelter.
__I would need someone to wait with me because

9. Which of the following statements best describes you?
(Check only one response)
__I have never used the COTA fixed route bus.
__I have used the COTA fixed route bus, but not since the onset of my disability / health condition.
__I have tried to use COTA fixed route bus, but was unable because
__I have used the COTA fixed route bus within the last six months.

10. Can you get to and from the COTA bus stop nearest your house by yourself?
__Yes __No__ Sometimes __Don't know where the stop is
If no or sometimes, check why:
__Hills __Curbs __No Sidewalks __Weather__Distance to the stop __Street Crossings

11. Can you grasp handles, railings, coins, and tickets?
__Yes __No __Sometimes __Don't know, never tried it
If no or sometimes, explain why:

12. Can you stand and maintain balance on a moving COTA bus when holding onto a pole or railing?
__Yes __No __Sometimes __Don't know, never tried it
If no or sometimes, explain why:

13. Do you have a current Driver's License? __Yes __No

14. How do you currently travel? *(Check all that apply)*
__Bus how many times per month?
__Paratransit how many times per month?
COTA Demand Response, First Transit, *(circle the ones you use)*
__ Taxi How many times per month?
__Drive myself How many times per month?
__Someone drives me how many times per month?

15. Please provide the address of the places you travel to most often. (Such as doctors, physical therapist, work, stores, restaurants, friends, or relatives)
Place Address

16. Please add any other information that you would like us to know about your abilities or disabilities.

I certify that the information in this application is **true** and **correct**. I understand that knowingly falsifying the information could result in denial of service. I understand that all information will be kept confidential, and only the information required to provide the services I request will be disclosed to those who perform the services. I understand that it may be necessary to contact a physician who is familiar with my functional abilities to use the Demand Response in order to assist in the determination of eligibility.
I understand that COTA Demand Response is a curb-to-curb service. Drivers are not permitted to enter any structure to find me or assist me to the curb. If I am determined eligible for Demand Response, I must be able to get to and from the curb. I understand that it is my responsibility to notify COTA if my condition changes. If my condition improves after I have been determined eligible, I may be asked to reapply. I understand that periodically, I may need to complete a recertification to remain eligible for COTA Demand Response services. I understand that I must complete the *Certification for Personal Care Attendant* on the next page if I require the assistance of a personal care attendant.

Signature _____ Date_____

Did someone help you in filling out this form? __Yes __No
Can we contact this person for additional information? __Yes __No
Name_____ Phone number_____ Relationship_____

COTA Demand Response
Certification for Personal Care Attendant

A personal care attendant is someone whose help you require for daily life activities (eating, dressing, personal hygiene, carrying packages, finding your way, etc.). An attendant does not always have to be the same person.

1. Do you require a Personal Care Attendant (PCA) or escort to accompany you when you travel?

2. If you checked **YES,** please list the name(s) of your PCA (agency or escort):

   Name: _____Address:_____Telephone: _____

   Name:_____Address:_____Telephone: _____

I certify that due to my disability, I require the services of a personal care attendant to assist me on a regular basis and travel with me on COTA Demand Response. I understand that COTA reserves the right to contact my physician to verify my need for an attendant. I understand that fraudulently claiming to travel with an attendant to avoid paying a fare for a companion may result in suspension of service.

Signature_____ Date_____

Authorization Form for Disclosure
Of Protected Health Information

I, _____, authorize:
(Print name of applicant)
_____, who is completing the Physician Verification Form
(Print name of Physician)

On my behalf, to release this information about my disability and abilities to representatives of the Commonwealth Office of Transit Authority (COTA) for their review, as well as any supporting or other pertinent information about my health or medical condition to assist COTA solely for the purpose of determining eligibility for COTA Demand Response Americans with Disabilities Act (ADA) paratransit service. I understand that all medical information about my disability will be kept strictly confidential.

I understand that I do not have to sign this authorization in order to be considered for services, but I understand that no weight will be given to medical conditions claimed which cannot be verified. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by the Federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. I have the right to revoke this authorization in writing except to the extent that COTA has acted in reliance upon this authorization. My written revocation must be submitted to Commonwealth Office of Transit Authority at 2nd Floor, Marianas Business Plaza Susupe, Suite. 206. Caller Box 10007 Saipan MP 96950

_____ _____
Signature of Applicant or Legal Guardian Date

(NOTE: May be signed by a legal guardian with power of attorney only if documentation showing your legal authority to act and sign on applicant's behalf is also provided.)

Applicant/Guardian must be provided with a copy of this authorization form.

Attention Physician:
Please return a copy of this signed authorization with the completed Physician Verification Form.

DEMAND RESPONSE
PHYSICIAN VERIFICATION FORM

Dear Physician:

You are being asked to provide information regarding the applicant's impairments as part of his/her application for COTA Demand Response service. COTA Demand Response is a specialized curb-to-curb transportation service provided as required by the Americans with Disabilities Act (ADA). The Demand Response service is provided to people who, due to an impairment, are prevented from using fixed route transit, like COTA's regular bus service. Eligibility for Demand Response service is not granted because a person finds it difficult or uncomfortable to get to and from bus stops or to ride the bus. Likewise, age, apart from disability, does not confer eligibility. An applicant must be **UNABLE** to utilize the fixed route bus system.
COTA will use the information you provide as part of our process to determine if applicants are prevented from using regular transit or if they have the functional ability to use the fixed route bus. If you have questions about the process, please call our Office at (670) 664-2690.

Applicant's Name_____ Date of Birth_____

_____
Applicant's Mailing Address City/State/Zip
(In the event we receive this PVF prior to the patient's application, we use this information to mail the patient an application request.)

1. In what capacity do you know this applicant? _____

2. When was your last evaluation of this applicant? _____

3. Can this applicant travel alone outside the home? Yes_____ No_____ Don't Know _____

4. Does this person take medications that would affect his/her ability to travel on public transportation? Yes _____ No _____ If yes, explain_____

5. If traveling alone, does the applicant have the ability to?
Wait outside at a bus stop for 10 to 15 minutes? Yes____ No____ Don't Know ____

Grasp handles, coins, tickets? Yes____ No____ Don't Know ____
Stand and maintain balance on a moving bus if holding a railing/pole?
Yes____ No____ Don't Know ____

Cross streets safely and find a bus? Yes____ No____ Don't Know ____

Understand and follow a bus schedule? Yes____ No____ Don't Know ____

Communicate needs? Yes____ No____ Don't Know ____

The sections on the following pages pertain to specific types of conditions or impairments. Please complete *ONLY* those sections that apply to this applicant.
Physician Verification Form 1 of 3

1. Briefly describe the impairment or condition and any corresponding limitations:
_____
2. Does this person use a mobility aid? Yes No If yes, circle those used:
Manual Wheelchair / Power Wheelchair / Cane / Walker / Scooter / Crutches / Leg Braces
Other: _____

3. How far can the applicant walk with mobility aid(s), or travel in a wheelchair?

Less than 1 block ___1 to 2 blocks___ 3 to 6 blocks___ 7 or more blocks ___Don't Know___

4. Is this condition temporary? ____Yes ____No ____Don't Know

If yes, how long will this condition last? _____

1. Briefly describe the visual impairment and any corresponding limitations:

2. Does this visual impairments affect this person's ability to travel on public transit: Yes__ No__?
If yes, explain: _____

3. Is this condition temporary? Yes_____ No_____ Don't Know_____

If yes, how long will this condition last? _____

1. Briefly describe the impairment or condition and any corresponding limitations:

2. Does this impairment or condition affect this person's ability to travel on public transit?
Yes _____No_____

If yes, explain: _____
3. Is this person a risk to others or themselves, especially when in close quarters?
Yes_____ No_____

If yes, explain: _____

4. Does this person demonstrate inappropriate social behavior (i.e., is he/she aggressive or overly friendly)?
Yes _____No_____
If yes, explain: _____

Physician Verification Form 2 of 3

1. Please describe the impairment and any corresponding limitations:

2. Does this impairment impact this person's ability to use public transit? Yes_____ No_____

If yes, explain: _____

3. Does the applicant experience seizures? Yes_____ No_____

If yes, what type of seizures and how often? _____

4. Does this person demonstrate inappropriate social behavior (i.e., is he/she aggressive or overly friendly)? Yes_____ No_____

If yes, explain: _____

Does the patient's impairment prevent him/her from riding the *Fixed Route System?
Yes_____ No_____

By my signature, I certify that this information is true and correct. I understand that the falsification of the information may result in denial of service to the applicant. I understand that all information will be kept confidential.

Dr. Signature_____ Date_____
Form MUST be signed by Medical Doctor

Print Name _____ **License #_____**

Address _____

Phone _____

Fax form to: (670) 664-2692
Or mail form to:
Commonwealth Office of Transit Authority
2nd Floor Marianas Business Plaza
Susupe, Suite 206
Caller Box 10007
Saipan MP 96950
If you are not the applicant but have completed this application on the applicant's behalf, you must provide the following information:

Full name (Print):_____ Telephone: _____

Mailing Address: _____City: _____ State_____ Zip Code: _____

Relationship to Applicant: _____

I hereby verify that to the best of my knowledge the information given above is correct and can be verified by the applicant's health care professional.

Signature: _____ Date_____ (mm/dd/yyy)

Please give directions and draw a map to your residence in this space.