Harford Transit LINK

Application for Reduced Fare (for fixed route service) and/or Demand & Response/ADA Paratransit Services

There are several types of public transportation available throughout the State of Maryland, depending on the county in which you reside. We are pleased to inform you that Harford County, through the cooperation of County Executive Barry Glassman and the County Council, offers citizens a Fixed Route System, Demand & Response and ADA Paratransit services within Harford County.

Fixed Route Service: Bus service has designated bus stops along specific routes on set schedules. All buses now have features to make riding easier for people with disabilities, including wheelchair lifts or ramps and some buses have kneeling features, low floors and voice announcements. For Fixed Route schedules and maps please see our website: http://www.harfordtransitlink.org .

Demand & Response and ADA Paratransit Service: Is Origin-to-Destination (in accordance with Harford County's/Harford Transit LINK's Policy Manual) shared ride public transportation service for people whose disability and/or residential location prevents them from using Fixed Route Service. You must call in advance to make a reservation to travel. We also created a Riders Guide to help you understand how to ride the Harford Transit LINK system. You can access the Riders Guide at the following website: http://www.harfordcountymd.gov/238/Ride-Guides .

If your disability or environmental barriers prevent you from using our Fixed Route Service you may be eligible for Demand & Response (Origin-to-Destination, Paratransit) Service some or all of the time. Your ability to ride Fixed Route buses will be evaluated through the use of this application, an in-person interview and in some cases a functional assessment. A determination will be made within 21 days of your in-person interview or a presumptive eligibility will be granted until a determination of eligibility is made. When you are contacted for your in-person interview, it is to your benefit to schedule as soon as possible. Your application will not be processed without this step.

IMPORTANT: Medical condition or eligibility for other disability programs does not necessarily qualify you to use the Demand & Response (Paratransit) Service (Origin-to-Destination). Not having access to the fixed route bus service is not a qualifier.

What is the American with Disabilities Act (ADA)?

The Americans with Disabilities Act (ADA) is a civil rights law. The intent of the ADA is to remove barriers that have prevented people with disabilities from fully participating in life. **Under the ADA, Fixed Route Service is to be the primary means of public transportation for everyone, including people with disabilities.**

Travel Training: Harford Transit LINK offers free one-on-one and/or group training to teach people with disabilities and service providers how to ride our Fixed Route buses. For more information, please call to request travel trainer services at: 410-612-1620.

(Print) Applicant's Name:

Harford Transit LINK

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To ensure your application is processed in a timely manner, all questions must be answered. **Part A and Part B must be submitted at the same time**. **<u>Incomplete applications will be returned to the applicant and/or individual/agency completing the application.</u>** All information is kept confidential and may be utilized for internal and/or operational purposes including contact with customer's treatment centers/employees and other contacts provided by the applicant/customer.

PART A: General information regarding the applicant. To be completed by applicant or an individual on behalf of the applicant. **<u>I hereby authorize the release of information requested on this application for use in evaluating my eligibility for services operated by Harford Transit LINK's Bus System of Harford County. I authorize LINK staff to contact the professional(s) who completed this form if clarification of information is needed, and I authorize the professional(s) to release all pertinent information to Harford LINK employees.</u>**

❑ Current Rider ❑ New Applicant

Name: Last	First	MI
Street Address:		(Apt. or Room No.)
Name of Development or Apartment Complex:		
City:	State:	Zip:
Mailing Address if different:		
Home Phone:	Cell Phone:	Work Phone:
Email Address:		
Date of Birth:	Last four (4) Digits of SSN:	Weight in lbs:
Client ID# __________________	Driver License or State ID #____	
Other: _________________	Passport # ___________________	Birth Certificate (copy) Provided? ❑ Yes ❑ No
Emergency Contact 1 Name:		Relationship:
Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -
Email Address:		
Emergency Contact 2 Name:		Relationship:
Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -
Email Address:		

If information is required in an alternative format, please call 410-612-1621

(Print) Applicant's Name:

Applicant must accurately and legibly complete each of the following questions.

1. Describe your disability and how you believe it prevents or limits your use of the regular fixed route bus service.

2. Is this condition/s temporary? ☐ Yes ☐ No
If temporary what is the expected duration _____Year(s) _____Month(s) or end date? ___/___/20___

3. Do you need a (PCA) Personal Care Assistant? ☐ Yes ☐ No ☐ Sometimes

4. How does the PCA assist you, such as getting to your destination or with activities after you arrive at your destination?

5. Do you need a Service Animal? ☐ Yes ☐ No
What type of service animal do you use?____________________

6. What task has the animal been trained to perform?

7. How do you travel now? Check all that apply.
❑ Fixed Route ❑ Paratransit ❑ Fixed Route and Paratransit
❑ Walk ❑ Drive a car ❑ Ride in a car ❑ Taxi ❑ Other______________

Have you used fixed route bus service before? ❑ Yes ❑ No ❑ Sometimes

Where do you go? ❑ Medical Appointments ❑ Work ❑ Senior Center ❑ Shopping ❑ Other(s)
List Other(s):

8. Which of these aids do you currently use when traveling? ***Check all that apply.***
❑ Portable Oxygen ❑ Prosthetic Leg ❑ Walker ❑ Manual Wheelchair

❑ Alphabet/Picture Board ❑ Leg Brace ❑ Cane ❑ Rollator

❑ Service Animal ❑ Crutches ❑ White Cane ❑ Power Scooter

❑ Power Wheelchair - Power Wheelchair – Weight________lbs. Height________ Width________

Note: Manual and Power Scooters and Wheelchairs must be able to be safely accommodated with the vehicle's lift and must be secured for transportation. Maximum Weight may vary upon lifts safety capacity when fully loaded.

9. Do you need assistance when you travel in the community? ☐ Yes ☐ No ☐ Sometimes
What type of assistance do they provide for you?

10. Can you climb three steps (11 to 15 inches) with a handrail, without assistance from another person? ☐ Yes ☐ No ☐ Sometimes

(Print) Applicant's Name:

11. Does weather impact your ability to use the fixed route bus system? ☐ Yes ☐ No ☐ Sometimes
Explain?

12. Describe the environmental barriers around your home or apartment that may prevent you from getting to the bus stop (i.e.: steps, sidewalk, hills, grass, gravel, distance, weather, air quality, etc.).

13. Are you able to navigate to the nearest bus stop without assistance? If no or sometimes, what prevents you? ☐ Yes ☐ No ☐ Sometimes

14. Can you cross streets with very little traffic where there are no traffic controls or stops signs without assistance?
If no or sometimes, what prevents you? ☐ Yes ☐ No ☐ Sometimes

15. Can you cross at traffic lights?
If no or sometimes, what prevents you? ☐ Yes ☐ No ☐ Sometimes

16. Can you cross at busy intersections with multiple lanes?
If no or sometimes, what prevents you? ☐ Yes ☐ No ☐ Sometimes

17. Are you able to ask for and follow written or oral information?
If no or sometimes, what prevents you? ☐ Yes ☐ No ☐ Sometimes

18. Are you able to recognize your destination or a landmark near your destination? If no or sometimes, what prevents you? ☐ Yes ☐ No ☐ Sometimes

19. Are you able to tell time? ☐ Yes ☐ No

20. Are you able to count money? ☐ Yes ☐ No

21. Are you able to read a bus schedule? ☐ Yes ☐ No

22. Are you able to read and understand a bus schedule with an assistive device? ☐ Yes ☐ No

23 Have you participated in Travel Training? ☐ Yes ☐ No

24. Do you require Travel Training? ☐ Yes ☐ No

25. Any other information that you would like to explain:

(Print) Applicant's Name:

Applicant Certification and Signature

Application must be signed to be considered complete.

I understand the purpose of this application form is to determine if there are times when I cannot use Harford Transit LINK's Fixed Route buses and will require Demand & Response/Paratransit services. I understand that the information on this application will be kept confidential and shared only with the appropriate County staff and other professionals involved in evaluating my eligibility. I certify that to the best of my knowledge, the information on this application is true and correct. I understand that providing false or misleading information could result in my eligibility status being terminated.

I give permission for Harford Transit LINK/County staff to contact the professional(s) who filled out information on this application or submitted supplemental verification of my condition.

Applicant Printed Name: Date: ___/___/20_______

Applicant Signature:

Person filling out this form if other than the Applicant (Check One)

❑ I certify that the information provided in this application is true and correct based upon my professional role and the information given to me by the applicant.

❑ I certify that the information provided in this application is true and correct based upon my own knowledge of the applicant's health condition or disability or I have legal authority to complete this application.

Print Name:	Signature:

Relationship to Applicant:

Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -

Street Address:	City:	State:	Zip:

Agency Name:	
Agency Address:	Phone: ( ) -

Parts A and Part B must be submitted together.
If only one section is received, the application will be returned to applicant.

Mail To:	Harford Transit LINK ADA and/or Reduced Fare Services 1311 Abingdon Rd Abingdon, MD 21009	Or Fax to: 410-612-1745 Or scan and email to: hcts@harfordcountymd.gov

Part B

Dear Health Care Professional,

If you do not have Part A from the applicant, you must return Part B to the applicant. Parts A and B must be submitted together.

In order to complete this application on behalf of the applicant, you must be a certified or licensed Health Care professional. (See Chart below for details of Health Professionals)

The applicant is asking you to review the information on this application and to complete and sign Part B of this form certifying that the applicant has a disability that prevents them from using the fixed route bus service. This information will be used to determine if the applicant qualifies for Demand & Response (Paratransit) service Origin-to-Destination (in accordance with Harford County's/Harford Transit LINK's Policy Manual) or is able to use the fixed route service for some or all travel.

Under the Americans with Disabilities Act (ADA) if a person has the functional and cognitive ability to use Harford Transit LINK's Fixed Route system the applicant is not eligible for paratransit services. Disability alone, distance to and from the bus stop, or the availability of Fixed Route bus service, is not by itself a qualifier for paratransit services (i.e.: Demand & Response, Origin-to-Destination services).

All of Harford Transit LINK's (Fixed Route and Demand & Response) vehicles are equipped with wheel chair lifts or ramps for individuals utilizing wheel chairs or by individuals unable to use the steps. Some buses can kneel or may be lower to the ground. In some cases, taxis may be utilized. Harford Transit LINK also offers **Travel Training** to assist persons with disabilities to use the fixed route bus service.

If you have any questions about completing Part B please call 410-612-1621

Minimum State Licensed or Certified Health Professionals	
Certified Nurse Practitioner	Physician Assistant
Licensed Clinical Psychologist	Podiatrist (foot and ankle disability only)
Optometrist (visual disabilities only)	Psychiatrist (psychiatric disability only)
Physician	Registered Nurse

(Print) Applicant's Name:

Part B

Part A must be attached.

A Licensed/Certified health Care Professional with knowledge of the applicant's functional abilities must complete this form.

Required Licensed/Certified Health Care Professional Information:

Name: Professional Title:

Professional Specialization: Professional License Number:

Clinic or Agency:

Address: City: State: Zip:

Phone: ( ) - Fax: ( ) - Email:

Please include all applicable information in order to avoid delays in processing the applicant's application.

General Medical or Physical Disability Information

Applicant has been a patient of mine since: ________/________/__________

Date of Applicant's last evaluation: ________/________/__________

Indicate the nature of the applicant's condition or disability. This list is not inclusive. Check all that apply.

❑ Currently receiving dialysis

❑ Undergoing Cancer Treatment Expected Duration____________________

❑ Arthritis Type and area(s) affected:________________

❑ Amputation Extremity____________ Prosthesis ❑ Yes ❑ No

❑ Neurological Cognitive Condition ❑ Mild ❑ Moderate ❑ Severe ❑ Profound

❑ Pulmonary Disease Oxygen sage_______________________________

❑ Hearing Impairment Degree of hearing loss: _________________________

❑ Diabetes	❑ Mental Illness
❑ End Stage Renal Disease	❑ Traumatic Brain Injury
❑ Neuromuscular Condition	❑ Legally Blind
❑ Cardiac Disease	❑ Severely Visually Impaired
❑ Alzheimer's	❑ Dementia
❑ Autism	Other :

(Print) Applicant's Name:

Section A - Seizure Disorder

Does the applicant experience Seizure's? If not, proceed to Section B - Cognitive Disorder

Does Applicant have a Seizure Disorder? ❑Yes ❑ No (If Yes) Type ________________________

How often? _____________________________________Recovery Time____________________________

Are seizures preceded by an aura? ❑Yes❑No Is applicant taking seizure medication? ❑Yes ❑No

Are seizures currently controlled? ❑Yes❑No When was the applicant's last seizure? ___/___/_____

Is the applicant able to function safely and effectively in the community? ❑Yes ❑ No

Is the condition temporary? ❑Yes ❑No Expected End Date: _____/_____/_______

What is the expected duration? _______ Year(s) _______ Month(s) ❑Permanent

Section B - Cognitive Disorder

Does the applicant have a Cognitive Disorder? If not, proceed to Section C - Behavior Health.

What is the formal diagnosis of the applicant's condition?

Does the applicant have specific behavioral problems? ❑ Yes ❑ No

Describe:

Is the applicant able to travel alone? ❑Yes ❑No

Does the applicant have the ability to follow directions? (check one) ❑ Yes ❑ No

❑ One Step Direction ❑ Two Step Directions ❑ Three Step Directions ❑ None

Would the applicant know what to do if they became lost out in the community? ❑ Yes ❑ No

Would the applicant be able to recognize and avoid dangers they might encounter when traveling in the community? ❑ Yes ❑ No

Does the applicant have the ability to safely cross streets? ❑ Yes ❑ No

Please check all that apply to safely cross streets at intersections. Provide additional information.

❑ Problem Solving	❑ Short Term Memory
❑ Attention	❑ Processing
❑ Foresight/Planning	❑ Safety Awareness and Judgment

❑ Additional Information:

(Print) Applicant's Name:

Section C - Behavioral Health	
Does the applicant have a Behavioral Disorder? If not, proceed to Section D - Visual Disability	
What is the formal diagnosis of the applicant's condition?	
What is the prognosis for this condition for independent function?	
Has the applicant been prescribed medications for their condition? If yes, does this application attest the applicant can function safely in the community? Explain if necessary:	❑ Yes ❑ No ❑ Yes ❑ No
Has the applicant recently had a decline in function due to an adjustment in medication?	❑ Yes ❑ No
Does the applicant experience auditory or visual hallucinations? How do the hallucinations impair the applicant's ability to function in the community?	❑ Yes ❑ No
Does the applicant experience anxiety or panic attacks in closed or crowded places? Explain:	❑ Yes ❑ No
Are there life skills that the applicant lacks that would prevent them from safely using county bus service? If yes, explain:	❑ Yes ❑ No
Section D - Visual Disability	
Does the applicant have a Visual Disability? If not, proceed to CONCLUSION.	
What is the formal diagnosis of the applicant's condition?	
Best corrected vision	
What is the prognosis? Is the condition stable, degenerative or otherwise changing?	
Visual Disability (continued):	

(Print) Applicant's Name:	
Describe applicant's ability to safely and independently maneuver in the community.	
❑ Only on their property or familiar places	❑ Quiet streets with very little traffic
❑ To nearby places in the same block	❑ Cross busy intersections/multiple lanes
❑ With auditory cross signals only	❑ At traffic lights
❑ Other:	
If the applicant is partially sighted, are they able to see steps and curves? ❑ Yes ❑ No Explain:	
Is vision affected by different lighting conditions?	❑ Yes ❑ No If yes, please check all that apply.
❑ Bright sunlight	❑ Applicant will benefit w/large print schedules
❑ Nighttime	❑ Other:
❑ Dimly lit or shaded places	
CONCLUSION	
Is the applicant's ability to travel outside alone affected by other conditions, such as environmental noise and ability to distinguish traffic flow patterns? Explain: ❑ Yes ❑ No	
With training could the applicant independently travel and use the county bus service? ❑ Yes ❑ No If no, explain:	
How far can the applicant properly operate a wheelchair and/or ambulate with or without a mobility aid without lengthy rest breaks? ❑ No independent functional mobility ❑ Greater than ½ mile ❑ Greater than ¼ mile ❑ Do their own shopping (walk around Mall) Applicant can walk approximately _______City Blocks	
How long can applicant wait at a bus stop **with** a bench and shelter? _______ Hour(s) _______ Min(s)	
How long can applicant wait at a bus stop **without** a bench and shelter? ______ Hour(s) ______ Min(s)	
Provide other vital information that will help the Agency make an appropriate eligibility determination.	
Mail To: Harford Transit LINK ADA and/or Reduced Fare Services 1311 Abingdon Rd Abingdon, MD 21009 Or FAX To: 410-612-1745 Or Scan and email to: hcts@harfordcountymd.gov	
END OF APPLICATION	