



Dear Applicant,

At your request, please find enclosed an Application packet including:

1. Application Instructions
2. Part I-Application
3. Professional Verification Cover Letter
4. Part II-Application (Professional Verification)
5. Authorization to Disclose Medical Information to Para transit Access Line

Part I: Can be completed by you alone or with the assistance of another person.

Please answer all questions contained in Part I of the Application. **Failure to answer any question or to provide a recent photograph will delay processing your application.**

Those questions, which require explanations, should be brief, but accurate. When you have completed Part I, please forward it, along with Part II, to a licensed or certified health care professional (refer to the list in Part II) who is currently treating you for your disability.

Part II: must be completed by a licensed or certified health care or rehabilitation professional, who is currently treating you for your disability, or a licensed or certified health care or rehabilitation professional who you visit for a paratransit evaluation, and whose title is listed on page 1, part 2.

Your eligibility will be carefully determined through a certification process in compliance with the regulations of the Americans With Disabilities Act of 1990. An accurate determination depends on the answers and information provided by you for evaluation. Inaccurate or false information may lead to denial or suspension of service.

**You will be advised of your eligibility status in writing no later than 21 days after our receipt, of both parts of your fully completed application.**

If you are denied eligibility, the reason for the denial and procedures to appeal the denial of eligibility will be detailed in that letter.

If you have any questions about the Application or the review process, please contact Paratransit Access Line, at (716) 855-7268 or 855-7377 TDD..



\*\*\*\*\*PLEASE PRINT\*\*\*\*\*

**PART I**  
**APPLICATION FOR PARATRANSIT SERVICE**  
**TO BE COMPLETED BY THE APPLICANT**

The information on this form will be used solely for the purpose of determining eligibility for the Paratransit Access Line. The information that you furnish will be kept strictly confidential.

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

Address: \_\_\_\_\_  
(Number and Street) (Apt. #)

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security: \_\_\_\_\_  
Month/Day/Year

1. Do you have a disability? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please describe any physical, mental, visual or cognitive disabilities, which **prevent** you from using the fixed route bus system.

How does this disability prevent you from boarding, riding, exiting or navigating the fixed route system? \_\_\_\_\_

(Please attach any additional documentation which you feel will support your inability to travel to and from a boarding or disembarking location, or to board, ride or exit a fixed route bus.)

If no, please explain why you think you are eligible for Paratransit.

2. Is your disability a permanent condition? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, how long do you expect to have this disability? \_\_\_\_\_

3. Do you use any of the following mobility aids? (Please check all that apply)

☐ Motorized Wheelchair ☐ Manual Wheelchair ☐ Powered Scooter

☐ Personal Care Attendant ☐ Walker ☐ Cane

☐ Crutches ☐ Service Animal ☐ Prosthesis

4. Can you walk/travel 200 feet without the assistance of another person?

Yes \_\_\_\_\_ No \_\_\_\_\_ Sometimes \_\_\_\_\_

Can you walk/travel  $\frac{1}{4}$  mile without the assistance of another person?

Yes \_\_\_\_\_ No \_\_\_\_\_ Sometimes \_\_\_\_\_

Can you walk/travel  $\frac{3}{4}$  mile without the assistance of another person?

Yes \_\_\_\_\_ No \_\_\_\_\_ Sometimes \_\_\_\_\_

Can you climb three 12-inch steps without assistance?

Yes \_\_\_\_\_ No \_\_\_\_\_ Sometimes \_\_\_\_\_

Can you wait outside without support for ten minutes without assistance?

Yes \_\_\_\_\_ No \_\_\_\_\_ Sometimes \_\_\_\_\_

Can you deposit your bus fare independently?

Yes \_\_\_\_\_ No \_\_\_\_\_ Sometimes \_\_\_\_\_

5. Where is the closest bus stop to where you live? \_\_\_\_\_

6. How far is this stop from where you live? Within a city block \_\_\_\_\_

$\frac{1}{4}$  mile \_\_\_\_\_  $\frac{1}{2}$  \_\_\_\_\_  $\frac{3}{4}$  \_\_\_\_\_ unsure \_\_\_\_\_

7. Do you currently ride a Metro fixed route bus/rail independently?

Yes \_\_\_\_\_ No \_\_\_\_\_ Sometimes \_\_\_\_\_

8. Have you ever received mobility training to use the Metro bus system?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what was the year you received that training? \_\_\_\_\_

Name of Training Person/Agency \_\_\_\_\_

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

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

Was the training complete? Yes \_\_\_\_\_ No \_\_\_\_\_

9. Does weather impact your ability to travel? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please explain how weather condition(s) impact your ability to ride the  
Fixed route bus/rail system. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. How do you currently travel?

- |   |  |
|---|--|
| <input type="checkbox"/> Van Service(s)     | <input type="checkbox"/> Agency Transportation |
| <input type="checkbox"/> NFT Metro Bus/Rail | <input type="checkbox"/> Taxi                  |
| <input type="checkbox"/> Other              |  |

11. Does Medicaid, Social Services, or your school system provide you with  
transportation to any of the following programs or activities. (check all that  
apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Nutrition            | <input type="checkbox"/> Community Action Programs       |
| <input type="checkbox"/> Senior Centers       | <input type="checkbox"/> Workshop                        |
| <input type="checkbox"/> Day Treatment        | <input type="checkbox"/> Retire Senior Volunteer Program |
| <input type="checkbox"/> Medical Appointments | <input type="checkbox"/> Community Residence             |
| <input type="checkbox"/> School/Day Care      | <input type="checkbox"/> Other                           |

I hereby affirm that the statements made herein are true and correct and I authorize the completion of this form and/or the release of related information to NFTA, Special Services Department.

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Signature of Applicant

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Date

If someone other than the applicant completed this form on behalf of the applicant, that person must complete the following:

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

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

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

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

Please enclose a recent photograph of yourself to be used on your Paratransit identification card. If Paratransit services are denied the photo will be returned.



**PART II (Professional Verification)**  
**APPLICATION FOR PARATRANSIT SERVICE**

**\*\*\*\*\*PLEASE PRINT\*\*\*\*\***

This part of the application form should be completed by one of the following professionals **who is currently treating the applicant for their disability**, or one of the following professionals **who will complete the application for the sole purpose of evaluating how your disability affects your functional mobility**:

**Check one item of six boxes to identify your profession**

- ☐ Physical Therapist certified by the American Physical Therapy Association;
- ☐ Occupational Therapist certified by the American Occupation Therapy Association;
- ☐ Certified Rehabilitation Counselor, Case Manager, or Social Worker;
- ☐ Physiatrist (**NOT Psychiatrist**)
- ☐ Orientation and Mobility Specialist certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP) or the National Blindness Professional Certification Board.
- ☐ Qualified Mental Retardation Professional (QMRP);

Applicant Name: \_\_\_\_\_

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

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

1. In what capacity do you know the applicant and for how long? \_\_\_\_\_

2. Is the applicant your regular client? **Yes** or **No** (please circle one)

3. Please list the medical diagnoses of all disabilities which functionally prevent the Applicant from: 1) getting to or from a Metro bus stop or rail station; 2) boarding or disembarking an accessible Metro bus or rail car; 3) riding or navigating an accessible Metro Bus/Rail; **(Please type or print clearly.)** \_\_\_\_\_
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4. Is the condition temporary? **Yes** or **No** (please circle one)  
If yes, then specify the time frame (example: 6 months) within which you anticipate the applicant to recover. \_\_\_\_\_

5. Is this condition likely to worsen? **Yes** or **No** (please circle one)

6. Does applicant have additional contributing visual and/or mental conditions that prevent travel? **Yes** or **No** (please circle one)

7. Under which category specified below is the applicant applying for eligibility to to utilize NFT Metro Paratransit Service(s). **Check all that apply**

A.

SECTION 1-Non-Ambulatory Disability  
SECTION 2-Mobility Aid  
SECTION 3-Arthritis  
SECTION 4-Amputation  
SECTION 5-Cerebrovascular Accident  
SECTION 6-Pulmonary Ills  
SECTION 7-Cardiac Ills  
SECTION 8-Dialysis  
SECTION 9-Disability of Incoordination  
SECTION 10-Cerebral Palsy  
SECTION 11-Epilepsy  
SECTION 12-Visually Impaired/Blind  
SECTION 13-Cognitive

- B. Which statement best describes the applicant's need for Paratransit Services? **(Check all that apply)**

- 1) Has a severe physical, mental, or visual disability which makes it impossible to use the NFT Metro accessible Bus/Rail system under any circumstances.

☐

- 2) Has a mobility problem which prevents the applicant from boarding an accessible vehicle without the assistance of a personal care attend ☐
- 3) Has a mental or visual impairment which prevents him/her from remembering & understanding all the applicant must do to find their way to and from a NFT Metro Bus/Rail stop and ride the system. ☐

**Circle one of the following:**

The Applicant will never have the ability to learn how to use the NFT Metro System even with mobility training,  
or

With mobility training the applicant is capable of learning how to use the NFT Metro System.

- 4) The applicant can use the NFT Metro Bus/Rail system sometimes, but for certain trips the individual has not been trained or there are other barriers present. ☐

8. In your opinion, under which of the two circumstances described in the ADA, Section 37.123(e) does the applicant qualify for paratransit service? **(please check one)**

- a. Any individual with a disability who is unable, as the result of a physical or mental impairment (including a vision impairment), and without the assistance of another individual (except the operator of a wheelchair lift or other boarding assistance device), to board, ride, or disembark from any vehicle on the system which is readily accessible to and usable by individuals with disabilities. **Yes or No (please circle one)**
- b. Any individual with a disability who has a specific impairment-related condition, which prevents such individual from traveling to a boarding location or from a disembarking location on such system. **Yes or No (please circle one)**



9. Does the applicant require use of the following? (check each, where it applies)

**PLEASE NOTE:** Wheelchairs must NOT exceed 30 inches in width and 48 inches in length measured two inches above the ground, and does not weigh more than 800 pounds when occupied.

	Yes	No	Sometimes	Width	Length	Weight
Manual Wheelchair	_____	_____	_____	_____	_____	_____
Motorized Wheelchair	_____	_____	_____	_____	_____	_____
Cane, crutches, or walker	_____	_____	_____			
Service animal	_____	_____	_____			
Personal Care Attendant	_____	_____	_____			
Sighted Guide/Escort	_____	_____	_____			
Oxygen	_____	_____	_____			

Is this person capable of making his/her own reservations and/or Cancellations independently? \_\_\_\_\_

10. Is the applicant able to do any of the following with the use of a mobility aid and without the assistance of another person?

	Yes	No	Sometimes
Travel 200 feet?	_____	_____	_____
Travel ¼ mile?	_____	_____	_____
Travel ¾ mile?	_____	_____	_____

11. Can the applicant climb three 12-inch steps without assistance \_\_\_\_\_

12. Can the applicant wait outside without support for 10 minutes \_\_\_\_\_

If No or Sometimes, describe in detail any factors which would have an adverse impact on the applicant's ability to wait outside. (example: extreme cold) \_\_\_\_\_

\_\_\_\_\_

13. Is the applicant able to:

Give addresses and telephone numbers upon request? \_\_\_\_\_

Recognize a destination or landmark? \_\_\_\_\_

Sign his/her name? \_\_\_\_\_

Deal with unexpected situations? \_\_\_\_\_

Ask for, understand, and follow directions? \_\_\_\_\_

Count money and pay fare? \_\_\_\_\_

Yes

No

\_\_\_\_\_

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**No**

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This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

I have read Part I of this application in its entirety. (Submitted by Applicant)

Yes \_\_\_\_\_ No \_\_\_\_\_

I agree with the information contained in Part 1 as provided by the applicant.

Yes \_\_\_\_\_ No \_\_\_\_\_

If no, please explain and provide specifics for each question you disagree with in Part 1.  
You may attach an additional sheet if needed.

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I hereby affirm that the statements made herein are true and correct.

Name: \_\_\_\_\_  
(Professionals Name Printed)

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

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

Office Phone: (\_\_\_\_) \_\_\_\_\_

New York State License/Certification Number \_\_\_\_\_  
(MUST PROVIDE)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Professionals Signature)

Specialty or Title & Agency: \_\_\_\_\_

**Please return this completed form along with Part 1 (previously completed by applicant) to:**

**NFTA Special Services/Paratransit  
181 Ellicott Street  
Buffalo, New York 14203**