



NASHUA TRANSIT SYSTEM
11 RIVERSIDE STREET
NASHUA, NH

The Nashua Transit System (NTS) is committed to ensuring equal access to its services for all individuals, regardless of disability. All of the information provided in this application is confidential. Please allow up to 21 days to complete the application process. In the event NTS fails to complete the determination within 21 days presumptive eligibility will be given until process is completed.

PART A: APPLICANT INFORMATION

NOTE: PLEASE ANSWER ALL QUESTIONS.

APPLICATIONS CANNOT BE PROCESSED WITHOUT PART D COMPLETED.

Please Type or Print Clearly

- checkbox New Application checkbox Renewal Application checkbox Temporary Application checkbox Visitor Application

Applicant Name: (First, Last, Initial) \_\_\_\_\_

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

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

Mailing Address (If Different): \_\_\_\_\_ Apt# \_\_\_\_\_

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

Home Phone #: \_\_\_\_\_ Second (Evening) Phone #: \_\_\_\_\_

checkbox Male checkbox Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Required for Verification Purposes

To be completed if the applicant was helped by another person in the completion of the application.

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

Relationship \_\_\_\_\_ Date \_\_\_\_\_

Person or agency to contact in case of an emergency:

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

Street \_\_\_\_\_ Apt# \_\_\_\_\_ Bldg # \_\_\_\_\_

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

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

# PART B: APPLYING FOR ADA CERTIFICATION

---

1. What are all of your current means of transportation? Please check all that apply.

- |  |   |
|--|---|
| <input type="checkbox"/> Walking                           | <input type="checkbox"/> Getting rides with family or friends |
| <input type="checkbox"/> Mobility aids or equipment        | <input type="checkbox"/> Taxi/car service                     |
| <input type="checkbox"/> Public transit bus (NTS City Bus) | <input type="checkbox"/> Commuter railroad                    |
| <input type="checkbox"/> Paratransit van (NTS City Lift)   | <input type="checkbox"/> Medicaid transportation              |
| <input type="checkbox"/> Driving yourself                  | <input type="checkbox"/> Other _____                          |

2. Which of the following mobility aids or equipment do you use to help you get to where you need to go?

Please check all that apply:

- |  |  |
|--|--|
| <input type="checkbox"/> Manual wheelchair       | <input type="checkbox"/> Respirator/Oxygen tanks         |
| <input type="checkbox"/> Power scooter           | <input type="checkbox"/> Guide cane                      |
| <input type="checkbox"/> Walker                  | <input type="checkbox"/> Service animal (guide dog, etc) |
| <input type="checkbox"/> Cane                    | <input type="checkbox"/> I do not use a mobility aid     |
| <input type="checkbox"/> Crutches                | <input type="checkbox"/> Other _____                     |
| <input type="checkbox"/> Prosthetic device/brace | _____  |

(Note: We may not be able to accommodate you if your wheelchair or scooter is longer than 48", wider than 30", or if your total weight with your mobility device is more than 600 pounds)

3. Using a mobility aid, equipment or standing on your own, what is the longest length of time that you can wait for transportation alone?

- |  |   |
|--|---|
| <input type="checkbox"/> 1-15 minutes  | <input type="checkbox"/> 45-60 minutes                    |
| <input type="checkbox"/> 15-30 minutes | <input type="checkbox"/> Over 60 minutes                  |
| <input type="checkbox"/> 30-45 minutes | <input type="checkbox"/> I cannot wait without assistance |

4. Using a mobility aid, equipment or walking on your own, how many blocks can you travel on level ground? Circle the answers below that best describe your abilities.

- |                                     |                             |                                 |                              |
|-------------------------------------|-----------------------------|---------------------------------|------------------------------|
| <input type="radio"/> 1-2 blocks    | <input type="radio"/> Never | <input type="radio"/> Sometimes | <input type="radio"/> Always |
| <input type="radio"/> 2-4 blocks    | <input type="radio"/> Never | <input type="radio"/> Sometimes | <input type="radio"/> Always |
| <input type="radio"/> 4-6 blocks    | <input type="radio"/> Never | <input type="radio"/> Sometimes | <input type="radio"/> Always |
| <input type="radio"/> 6-8 blocks    | <input type="radio"/> Never | <input type="radio"/> Sometimes | <input type="radio"/> Always |
| <input type="radio"/> Over 8 blocks | <input type="radio"/> Never | <input type="radio"/> Sometimes | <input type="radio"/> Always |

5. Are you able to climb three 12-inch steps without assistance?

- Yes       No

• If no, please explain: \_\_\_\_\_

6. Do you currently use any of the NTS City Bus routes?

- Yes                       No

• If yes, how many days in one week \_\_\_\_\_

• If no, please check all that apply:

- I have a disability which prevents me from boarding a NTS City Bus  
**(All NTS buses and vans are wheelchair accessible)**
- I have a disability that prevents me from getting to some NTS City Bus stops.
- I have a disability that prevents me from getting to all NTS City Bus stops.
- I am afraid to ride the NTS City Bus.
- I have no knowledge of or experience with the NTS City Bus system.
- There is no NTS City Bus stop near my residence.
- I cannot get to a bus stop by myself because I get disoriented or confused.
- I have a temporary disability that prevents me from taking a NTS City Bus.  
I will only need to use the NTS City Lift service until I recover.
- If given information, instructions or training on the NTS City Bus service, I think I could use it.
- My trip by NTS City Bus would take me too long.
- I have an episodic disability. I can only use the bus on those days when I am feeling well, but on "bad days", I cannot.

7. What would help you ride on the NTS City Bus if you are not currently using it?

• Please check all that apply:

- Lift accessible buses.
- Knowing more about the NTS City Bus
- I would travel if there were accessible City Bus routes where I need to go.
- Other (please specify) \_\_\_\_\_

8. Would you be able to get to or from the NTS City Bus route if you were to use it?

- Yes                                       Sometimes                                       No

• If only sometimes or not at all, please check all that apply:

- I cannot walk further than \_\_\_\_\_.
- I become confused or cannot remember where I am going.
- I do not want to ride the NTS City Bus system
- I cannot cross street or intersections because \_\_\_\_\_.
- I cannot get places without curb cuts, paved sidewalks, or if the ground is too uneven
- Other (please specify) \_\_\_\_\_

9. Would you be able to follow written or oral instructions to use the NTS City Bus?

- Yes                       No

10. Are you able to transfer from one NTS City Bus to another?
- Yes       No
- If no, please check all that apply:
    - I get too confused and might become lost
    - I do not like to transfer
    - I cannot hold a paper transfer
    - I do not want to use the fixed route and/or shuttle system
    - Other: \_\_\_\_\_

11. Would you be able to communicate with the bus driver by yourself?
- Yes       No
- If no, please check all that apply:
    - I cannot understand the driver
    - Other people cannot understand me
    - I need a communication aid and do not have one
    - Other (please specify): \_\_\_\_\_

12. Do you travel with a Personal Care Attendant (PCA, e.g., a person such as a home attendant or friend who assists you at your destination or when you travel)?
- No, I do not need a PCA
- Yes, I need a PCA to help me travel
- Yes, sometimes I need a PCA while I am at my destination

13. Is your disability temporary?
- Yes       No
- If yes, please indicate how long you believe the temporary disability will continue:
    - 1 month
    - 2 months
    - Other (how many months?) \_\_\_\_\_

14. Is your condition affected by the weather?
- Yes       No
- If yes please explain: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

15. If you have used the NTS City Bus in the past and have stopped using it, why did you stop?

---

---

---

---

---

---

16. Is there anything else you want to tell us about your disability or health condition that might help to understand your travel abilities or limitations better?

---

---

---

---

---

---

---

---

---

---

17. NTS offers Travel Training to individuals whom would be able to use the NTS City Bus system all or part of the time for routine trips rather than the NTS City Lift paratransit service. Would you be interested in travel training?

- Yes       No

• Please explain how we can help or why it would not be an option:

---

---

---

---

---

---

---

---

---

---

The questions on this page are **optional** and will not be used to determine eligibility. Please take the time to answer the following questions as they may help you understand the NTS City Bus system and it will help NTS determine if travel training might be your best option.

1. How far is the closest NTS City Bus stop to your home?

0 – 1 block

6 - 8 blocks

2 - 4 blocks

Over 8 blocks

4 - 6 blocks

I don't know

2. Frequent Destination(s)

Closest Bus Stop(s)

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

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

3. How do you currently travel to your most frequent destinations? Check all that apply:

City Bus

City Lift

Medicaid

Taxi

Someone drives me

Drive myself

Other (specify) \_\_\_\_\_

4. List the three (3) places you go to most often and how you get there now.

Where do you go? \_\_\_\_\_

Address \_\_\_\_\_

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

Where do you go? \_\_\_\_\_

Address \_\_\_\_\_

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

Where do you go? \_\_\_\_\_

Address \_\_\_\_\_

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

5. Do you need transportation at least three times each week for regularly scheduled trips to a particular destination?

Yes

No

• If yes, please check all that apply:

Dialysis

Adult Day Care

Therapy

Senior Center

School

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

Volunteer Work

Work

# PART C: APPLICANT AGREEMENT AND INFORMATION

---

## AGREEMENT TO ELIGIBILITY TERMS AND CONDITIONS

*(All applicants must sign this agreement)*

I understand that I must schedule an appointment with the mobility manager to review the information in this application. The purpose of this process is to determine if I am eligible to use ADA Paratransit Services. I affirm that all information that I provide on this application is true to the best of my knowledge. I understand that my application is subject to review and verification and that misrepresentation of any material information will lead to revocation of my registration. I also understand that failure to adhere to the policies and procedures for using the NTS City Lift service will be grounds for suspending my eligibility in this program.

X \_\_\_\_\_  
*Signature of applicant or Responsible Party* *Date*

## Authorization for Release of Information

*(All applicants must complete PART D)*

I authorize the professional who has completed PART D of this application to release information about my disability or health condition and its effect on my ability to travel on the NTS City Bus service. I understand that I may revoke this authorization at any time. Unless earlier revoked, this form will permit the professional completing PART D to release the information described up to 60 days from the date this application is reviewed with you by the NTS Mobility Manager. I understand that all medical information, which is provided, about my disability or health condition will be kept strictly confidential within the limits of the law.

X \_\_\_\_\_  
*Signature of applicant or Responsible Party* *Date*

## AMERICANS WITH DISABILITIES (ADA) APPEAL PROCESS

If your ADA paratransit eligibility determination results in a finding of ineligible to receive paratransit service or in a determination of limited or conditional eligibility and you feel that this determination has been made in error, you have the right to appeal this determination.

To file this appeal you must notify NTS in writing within 60 days of the date on the determination letter. After your appeal is received, a hearing will be scheduled to evaluate your case. The hearing process (which should not take more than 30 days) will allow you to present information and arguments on your behalf. You may have others present who are knowledgeable of your physical or mental impairment and who can speak on your behalf, but you must pay the cost for these other spokespersons. After the hearing you will be advised in writing of the decision of the appeal board. The decision of the appeal board is final.

NTS is not required to provide you with paratransit service while your appeal is under consideration. If the appeal board has not made its decision within 30 days of receiving your appeal, you are entitled to paratransit service from that time until a final decision is made.

If you currently have ADA eligibility then your eligibility and its conditions will not change for 60 days after a re-certification determination to allow the applicant time to transition to other means of transportation, receive travel training, and/or file an appeal. If you file an appeal then your service eligibility will immediately change pending the outcome of your appeal.

# PART D: HEALTH CARE PROFESSIONAL VERIFICATION

---

A licensed or certified health care professional that can verify your disability, health condition and understands your functional abilities must complete this part of the form. Examples of health care professionals who should complete this part include:

- Physician (M.D. or D.O.)
- Registered Nurse
- Psychologist

Dear Health Care Professional:

You are being asked to complete an assessment of the applicant's disability that prevents his/her ability to use the Nashua Transit System (NTS) fixed route bus system (City Bus). By completing and signing this document you (the health care professional) will be certifying the truth and accuracy of the information provided on this application, to the best of your professional knowledge.

The NTS ADA paratransit (City Lift) program is partially funded through the Federal government. Federal Law (*The American with Disabilities Act of 1990*) requires that NTS provide services to persons who cannot use our fixed route bus system (City Bus). However, resources for NTS City Lift services are limited and **Federal Law also requires that we strictly limit eligibility to only those whom need the service.** The information you provide will allow NTS to make an appropriate evaluation of this request for City Lift service.

To qualify for City Lift service, a person must be unable to use fixed route bus service and fulfill the following eligibility criteria:

- As a result of their disability, they cannot board, ride or disembark from a NTS City Bus.
- They have a specific impairment related condition that prevents them from getting to or from a City Bus.

Your evaluation of each person must be based solely upon the individual's ability to use the NTS City Bus. Please note that individuals are not eligible for this service if their disability or health condition only makes it inconvenient or more difficult to use the City Bus service. In addition I would like you to know that all NTS City Buses are accessible to persons with disabilities and each bus is equipped with a wheelchair lift, and a kneeling first step. Drivers also make stop announcements for visual impaired passengers.

On the proceeding page, the applicant should have signed "an authorization for release of information." Please note that all information regarding the applicant's disability and health condition will be treated strictly confidential by NTS to the maximum extent allowed under the law.

**If the application is not complete it may be returned to you for completion, and this will delay the processing of the application.**

Thank you for your assistance in providing vital information needed to determine eligibility for this important service. Feel free to call the NTS ADA eligibility office at 603-821-2030 to speak to the Mobility Manager at any time should you have questions about the service or this application.

1. Name of applicant: \_\_\_\_\_
2. Capacity in which you know the applicant: \_\_\_\_\_  
\_\_\_\_\_
3. On average how often is the applicant seen by you? \_\_\_\_\_
4. When was the applicant last treated or seen by you? \_\_\_\_\_



5. Please check all of the disabilities that would impair the applicant's ability to travel:

*Neuromuscular*

- Cerebral Palsy
- Muscular Dystrophy
- Parkinson's Disease
- Arthritis
- Stroke/Cerebral Trauma
- Quadriplegia
- Multiple Sclerosis
- Paraplegia
- Other: \_\_\_\_\_

*General Medical*

- AIDS
- Diabetes (severe)
- Lupus
- Cancer
- Epilepsy (severe)
- Kidney disease/Dialysis
- Other: \_\_\_\_\_

*Cardiovascular*

- Arteriosclerosis
- Cystic Fibrosis
- Emphysema
- Congestive Heart Failure
- Chronic Obstructive Pulmonary disease
- Peripheral Vascular disease
- Thrombosis (chronic)
- Asthma
- Heart Attack
- Other: \_\_\_\_\_

*Cognitive/Psychological*

- Alzheimer's disease
- Dementia
- Down's Syndrome
- Phobia
- Head Trauma
- Panic disorder
- Autism
- Schizophrenia
- Other: \_\_\_\_\_

<i>VISION</i>		
Check all that apply	One eye	Both eyes
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Cortical Blindness	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma (all types)	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>
Retinopathy	<input type="checkbox"/>	<input type="checkbox"/>
Legally Blind	<input type="checkbox"/>	<input type="checkbox"/>
Totally Blind	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>

<i>HEARING</i>		
Check all that apply	One Ear	Both ears
Partially Deaf	<input type="checkbox"/>	<input type="checkbox"/>
Completely Deaf	<input type="checkbox"/>	<input type="checkbox"/>

6. Does the applicant use any mobility aids?

- Yes                                       Sometimes                                       No

• If so, what type?

- |  |   |
|--|---|
| <input type="checkbox"/> Manual wheelchair | <input type="checkbox"/> Respirator/Oxygen tank             |
| <input type="checkbox"/> Walker            | <input type="checkbox"/> Service animal (guide dog, etc...) |
| <input type="checkbox"/> Power wheelchair  | <input type="checkbox"/> Cane                               |
| <input type="checkbox"/> Power scooter     | <input type="checkbox"/> Guide cane                         |
| <input type="checkbox"/> Crutches          | <input type="checkbox"/> Other: _____                       |

7. Can the applicant transfer from a wheelchair/other mobility aid to a passenger seat if necessary?

- Yes                                       No

8. Please circle yes or no to indicate whether the applicant can do any of the following:

- |   |                              |                             |                                    |
|---|------------------------------|-----------------------------|------------------------------------|
| <input type="radio"/> Travel 2 blocks (1/4 Mile) without assistance         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| <input type="radio"/> Travel 6 blocks (3/4 mile) without assistance         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| <input type="radio"/> Climb three 12-inch steps without assistance          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| <input type="radio"/> Stand for 15 minutes if there is no place to sit      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| <input type="radio"/> Give address and phone numbers upon request           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| <input type="radio"/> Recognize a destination or landmark                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| <input type="radio"/> Deal with unexpected situations or changes in routine | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| <input type="radio"/> Ask for, understand, and follow directions            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| <input type="radio"/> Safely cross street and intersections                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| <input type="radio"/> Be left unattended at a pick-up or drop-off location  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |

9. Is the applicant's condition temporary?

- No
- Yes, How long? \_\_\_\_\_ Explain: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

10. Do the applicants functional abilities to travel change due to medical treatments, medications, environmental conditions (heat, humidity, cold, ice, and snow) or other related factors?

- No
- Yes, Explain: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

11. Please provide (type or print) a narrative assessment of the applicant's functional level of mobility.

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

12. Would the applicant's condition prevent him/her from using the NTS City Bus?

No

Yes, Please explain in detail: \_\_\_\_\_

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

**X** \_\_\_\_\_  
Health Care Professionals Signature

\_\_\_\_\_  
Title:

\_\_\_\_\_  
Daytime phone number

\_\_\_\_\_  
Health Care Professionals Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Company Agency Name

\_\_\_\_\_  
Address

Thank you again for your assistance. NTS may contact the certifying Health Care Professional to verify accuracy of the information. NTS will make the final determination as to the applicant's eligibility.

**FOR NTS USE ONLY  
DO NOT WRITE IN THIS BOX**

Application Received: \_\_\_\_\_ Certification Date: \_\_\_\_\_ Status:  Eligible  Condition Eligibility  Denied

Entered to Database: \_\_\_\_\_ Letter Sent: \_\_\_\_\_ Appeal Date: \_\_\_\_\_

Eligibility Period:  3 years  1 year  Visitor  Temporary to \_\_\_\_\_

PCA Confirmed by: \_\_\_\_\_ Date: \_\_\_\_\_

Comments/Conditions: \_\_\_\_\_

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