VERIFICATION OF PARATRANSIT ELIGIBILITY

Healthcare Professional Assessment

This portion of the application form is to be completed by the Healthcare Professional most familiar with the applicant's abilities and disabilities as it relates to his/her ability to use the regular fixed-route Hele-On bus service.

The attached applicant has applied for ADA paratransit service with the County of Hawai'i Mass Transit Agency (MTA). You are being asked to provide information regarding this applicant's disability **as it affects his/her ability to use the regular fixed-route public transportation (Hele-On) bus service.** Please note that all of our buses are lift-equipped for individuals who use wheelchairs/scooters and who are unable to use the bus steps.

The County of Hawai'i Mass Transit Agency provides paratransit (origin-to-destination) service to persons who are unable to use the regular fixed-route Hele-On bus service.

An individual's eligibility is determined by three factors. Due to the individual's disability, the individual is:

- unable to get to/from the bus stop
- unable to board/exit the bus
- cognitively navigate the regular bus system

Not all persons with disabilities qualify for paratransit services.

To assist our office in determining eligibility status, please review the enclosed application as completed by the applicant and complete the attached verification of paratransit eligibility form.

Please note: Your certification should consider only the presence of a disabling condition(s) and its affect(s) upon the applicant's ability to use the Hele-On bus. A person does not qualify for ADA paratransit service if they find it difficult or uncomfortable to travel to or from bus stops. They must be unable to independently get to or from bus stops, ride the Hele-On bus, and/or navigate the system. This verification is one step in determining an applicant's eligibility for paratransit service. Final approval of eligibility is made by the County of Hawai'i Mass Transit Agency.

Should you have any questions regarding ADA paratransit eligibility, please contact the County of Hawai'i Mass Transit Agency at (808) 961-8343.

In order for the County of Hawai'i Mass Transit Agency (MTA) to evaluate your paratransit request, it is necessary to contact a health care professional to verify the information that you have provided.

Please list the name of the health care professional (licensed physician, therapist, social worker, nurse or specialist) designated by the applicant, who may be contacted by MTA.

Name of Health Care Professional: _____

Specialty/Title: _____

Office/Mailing Address: _____

City _____ State _____ ZIP _____ Phone (____)_____

I hereby certify that the information provided on my Hele-On Kako'o paratransit application is correct. I authorize the release of information and photos to County of Hawai'i Mass Transit Agency (MTA). I hereby authorize the MTA to contact the above-listed health care professional to release information regarding my disability to the MTA. The information about my disability will be used solely to determine my eligibility for paratransit services.

Unless otherwise revoked, this authorization will remain in effect until the following date or event: _____. If a date or event is not specified, this authorization will expire 90 days from the date of signature below.

This Authorization is voluntary. I understand that I can refuse to sign this Authorization and the above-named medical provider will not condition my treatment, payment, enrollment or eligibility for benefits on the signing of this Authorization except as allowed under federal privacy laws for: (i) research-related treatment, or (ii) health care provided solely for disclosure to a third party, or (iii) health plan initial enrollment/eligibility determinations, underwriting or risk rating determinations..

I understand that I may revoke this Authorization at any time by notifying the above-named medical provider, in writing, of my revocation. I understand that the revocation will not apply to any information that was already released in reliance on this Authorization.

I understand that the health information released under this Authorization may be re-disclosed by the County of Hawai'i and may no longer be protected under federal privacy regulations. I am entitled to receive a copy of this Authorization. A copy of this Authorization may be used with the same effect as the original.

I hereby release the above-named medical provider and the County of Hawai'i and its designated court reporter from all liability and all claims of any nature whatsoever pertaining to disclosure of information, or of any professional opinions, findings, or recommendations as contained in the records released to, or by, the above-named medical provider or the County of Hawai'i.

Applicant's Name (Print):_____Date:_____

Applicant's Signature:_____

(over)

I have reviewed the enclosed application and agree with the information provided for:

_____

(Applicant's Name)

___ Yes ___ No If **NO**, please explain why:

_____

_____

_____

_____

The applicant is unable to use the Hele-On bus because of:

Diagnosis:

_____

Which prevents ridership on the regular fixed-bus route because:

_____

_____

___ Temporary: Expected duration until _____/_____/_____

___ Long Term: Condition has potential for improvement or long periods of remission.
Recommend reassessment at: ___ 6 mos ___ 1 year

___ Permanent: Condition has no expectation of improvement.
(a maximum 3-year eligibility card can be issued)

I hereby certify that the above information is true. False verification may result in the disqualification of the application and/or eligibility for paratransit service.

_____ _____

Signature Date

Print Name _____ Title _____

Address _____

City _____ State _____ Zip _____ Phone (_____)_____

Please return all forms to:
County of Hawai'i
Mass Transit Agency
25 Aupuni Street
Hilo, HI 96720
(808) 961-8343

HELE-ON PARA-TRANSIT SERVICES KAKO'O

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):_____

Mailing Address: _____

City_____ State_____ Zip Code_____

Relationship to Applicant_____Daytime Phone_____

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

Signature:_____Date:_____