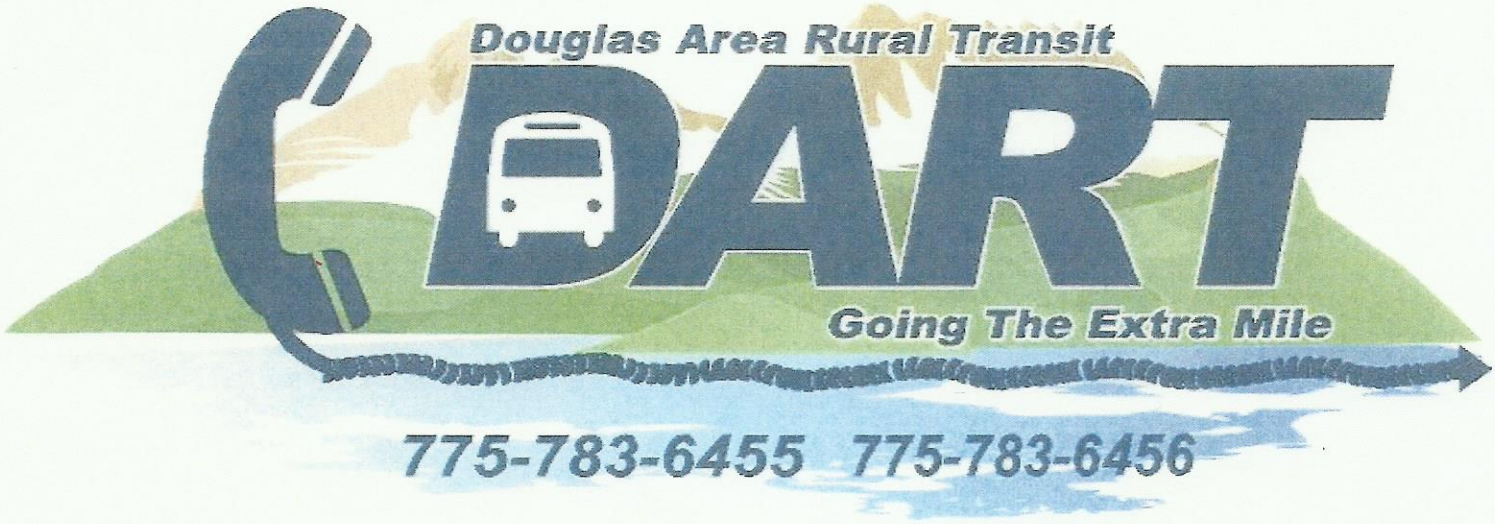
DART

DOUGLAS AREA RURAL TRANSIT



DIAL-A-RIDE

DROP AT:
MON-FRI
8AM-5PM

DART DIAL-A-RIDE TRANSIT SYSTEM
1329 WATERLOO LANE
GARDNERVILLE, NV 89410

MAIL TO:
DART TRANSPORTATION
P.O. BOX 218
MINDEN, NV 89423

Phone: (775) 783-6455 FAX (775) 783-6457

APPENDIX E

Dart Dial-A-Ride ELIGIBILITY APPLICATION

PART A

DROP AT: DART DIAL-A-RIDE TRANSIT SYSTEM
MON-FRI 1329 WATERLOO LANE
8AM-5PM GARDNERVILLE, NV 89410

MAIL TO: DART TRANSPORTATION
P.O. BOX 218
MINDEN, NV 89423

Phone: (775) 783-6455 FAX (775) 783-6457

DART Dial-A-Ride provides Curb-to-Curb transit services to the general public ALL RIDERS are Eligible to ride ANY service available. To become Eligible for service, applicants along with a Qualified Professional such as: Physician (M.D. or D.O.) or Registered Nurse, Physical or Occupational Therapist, Psychiatrist, Psychologist, or Mental Health Counselor, Vocational Counselor, Rehabilitation Specialist or Independent Living Skills Trainer, Licensed Social Worker or Case Manager, Orientation and Mobility Instructor or Travel Trainer, or Ophthalmologist MUST Complete and Submit Part A and Part B for Review. Applicants will also need to Complete an Authorization Form for Disclosure of Protected Health Information attached to PART B that will be Submitted by the Qualified Professional.

PLEASE TYPE OR PRINT IN INK TO COMPLETE ALL APPLICATION FORMS

LAST NAME: _____ FIRST NAME: _____ MI _____

ADDRESS: _____ APT. NO. _____

CITY/TOWN: _____ STATE: _____ ZIP _____

HOME PHONE: ( ) _____ WORK PHONE: ( ) _____

CELL PHONE: ( ) _____ DOB: ____ / ____ / ____

EMAIL ADDRESS: _____

DO YOU REQUIRE INFORMATION IN AN ALTERNATIVE FORMAT?

BRAILLE _____ LARGE PRINT _____ AUDIO TAPE _____ OTHER _____

IF SOMEONE IS HELPING YOU WITH THIS APPLICATION, THAT PERSONEL MUST COMPLETE THE FOLLOWING:

NAME: _____

ADDRESS: _____

HOME PHONE: ( ) _____ WORK PHONE: ( ) _____

EMERGENCY CONTACT INFORMATION

NAME: _____

RELATIONSHIP: _____

HOME PHONE: ( ) _____ WORK PHONE: ( ) _____

CELL PHONE: ( ) _____

INFORMATION ABOUT OUR ABILITIES

1. WHAT IS THE DISABILITY OR HEALTH CONDITION THAT PROVIDES FOR YOUR ADA USAGE OR DART DIAL-A-RIDE?

- ☐ CERTIFIED LEAGALY BLIND
- ☐ LOSS OR INABILITY TO USE ONE OR MORE LIMBS
- ☐ SEVERE EFFECTS OF STROKE
- ☐ PARALYSIS AFFECTING MOBILITY, SPEECH, VISION OR MEMORY
- ☐ SEVERE ARTHRITIS
- ☐ AUTOIMUNE DISORDERS, FOR EXAMPLE, LUPUS OR SCLERODERMA ECT.
- ☐ SEVERE CARDIAC AND/OR RESPITORY IMPAIRMENT AFFECTING STRENGTH AND/OR ENDURANCE
- ☐ DEVELOPMENTAL DISABILITIES, FOR EXAMPLE, MENTAL RETARDATION, CEREBRAL PALSY, EPILEPSY, AUTISM OR NEUROLOGICAL DISORDER, ETC.
- ☐ HEARING LOSS ACCOMPANIED BY AN INABILITY TO UNDERSTAND SPEECH WITH/WITHOUT A HEARING AIDE
- ☐ OTHER (PLEASE EXPLAIN): _____

A. IS YOUR DISABILITY PERMANENT? ☐ YES ☐ NO

B. IF YOUR DISABILITY IS TEMPORARY, HOW LONG DO YOU EXPECT IT WILL BE UNTIL YOU'RE BETTER?

_____ MONTHS

C. IS THERE A SEASON DURING THE YEAR THAT YOUR DISABILITY/HEALTH CONDITION WORSENS AND PREVENTS YOU FROM TRAVELING WITHOUT HELP? (CHECK ALL THAT APPLY)

☐ SPRING ☐ SUMMER ☐ FALL ☐ WINTER

2. DO YOU USE ANY OF THE FOLLOWING MOBILITY AIDS? CHECK ALL THAT APPLY.

- ☐ MANUAL WHEELCHAIR
- ☐ POWERED SCOOTER
- ☐ WALKER
- ☐ SERVICE ANIMAL
- ☐ OXYGEN
- ☐ ELECTRIC WHEELCHAIR
- ☐ CANE
- ☐ WHITE CANE
- ☐ CRUTCHES
- ☐ OTHER (PLEASE LIST) _____

3. DO CHANGES IN WEATHER (LIKE EXTREME HEAT, COLD, WIND, SNOW AND/OE ICE) COMBINED WITH YOUR DISABILITY OR HEALTH CONDITION STOP USING DART DIAL-A-RIDE SERVICES?

☐ YES ☐ NO

IF YES, EXPLAINE COMPLETELY. USE AN ADDITIONAL SHEET IF NECESSARY. _____

4. DO YOU REQUIRE THE ASSISTANCE OF A PERSONAL CARE ATTENDANT (PCA) WHEN YOU TRAVEL? (RIDERS MUST PROVIDE THEIR OWN PCA)

☐ YES ☐ NO ☐ SOMETIMES

5. ALL DART DIAL-A-RIDE TRANSIT SYSTEM VEHICLES HAVE WHEELCHAIR LIFTS (IF YOU ARE UNABLE TO CLIMB STAIRS, YOU CAN STAND ON THE LIFT). CAN YOU GET ON OR OFF THE BUS WITHOUT THE ASSISTANCE OF ANOTHER PERSON?

☐ YES ☐ NO ☐ SOMETIMES

IF YOU ANSWERED NO OR SOMETIMES, EXPLAIN WHY. _____

_____

6. DOES YOUR DISABILITY OR HEALTH CONDITION STOP YOU FROM GETTING TO OR FROM A BUS STOP WITHOUT HELP FROM ANOTHER PERSON, FOR ONE OR THE FOLLOWING REASONS? (CHECK ALL THAT APPLY)

☐ UNABLE (NOT JUST DIFFICULT) TO TRAVEL ON ROUGH OR HILLY TERRAIN
☐ EXTREME SENSITIVITY TO CERTAIN WEATHER CONDITIONS
☐ EXTREME FATIGUE DUE TO HEALTH CONDITION
☐ UNABLE TO CROSS BUSY INTERSECTIONS
☐ LACK OF SIDEWALKS AND CURB CUTS AT BUS STOP
☐ UNABLE TO LOCATE BUS STOP DUE TO A VISUAL IMPAIRMENT
☐ UNABLE TO WAIT OUTSIDE FOR TEN (10) MINUTES OR MORE
☐ UNABLE TO TRAVEL ON ICE OR SNOW COVERED SURFACES
☐ UNABLE TO IDENTIFY CORRECT BUS IN THE DAYTIME WHEN IT IS LIGHT
☐ UNABLE TO IDENTIFY CORRECT BUS IN EARLY MORNING OR EVENING HOURS WHEN IT IS DARK
☐ OTHER (PLEASE EXPLAIN): _____

7. INDICATE BELOW HOW FAR YOU ARE ABLE TO TRAVEL WITHOUT HELP.

☐ LESS THAN 200 FEET ☐ 1/4 MILE (3 BLOCKS) ☐ 1/2 MILE (6 BLOCKS)
☐ 3/4 MILE (9 BLOCKS) ☐ MORE THAN 3/4 OF A MILE

8. AFTER ARRIVING AT A BUS STOP, HOW LONG CAN YOU WAIT OUTSIDE (NOT SITTING) UNTIL THE BUS ARRIVES?

☐ 30 MINUTES OR LONGER ☐ 15 MINUTES ☐ 10 MINUTES ☐ LESS THAN 10 MINUTES

IF YOU CANNOT STAND WHILE WAITING, WHY NOT? _____

_____

9. WHICH OF THE FOLLOWING FUNCTIONS ARE YOU UNABLE TO PREFORM WITHOUT ASSISATNCE FROM ANOTHER PERSON (CHECK ALL THAT APPLY)

- ☐ UNDERSTAND AND/OR PROCESS INFORMATION?
- ☐ ASK FOR, OR FOLLOW WRITTEN OR ORAL INFORMATION, SUCH AS SCHEDULES INCLUDING TDD, AUDIO, TAPE OR VOICE?
- ☐ FIGURE OUT THE CORRECT FARE?
- ☐ FOLLOW INSTRUCTIONS IN AN EMERGENCY?
- ☐ RECOGNIZE YOUR DESTINATION WHILE ON THE BUS?
- ☐ ONCE YOU GET OFF THE BUS, LOCATE AND REACH YOUR DESTINATION?
- ☐ CROSS A BUSY INTERSECTION?
- ☐ FIND YOUR WAY BETWEEN FAMILIAR LOCATIONS?
- ☐ SIGNAL THE BUS DRIVER TO GET OFF THE BUS AT A FAMILIAR STOP THEN GET OFF THE BUS? ASSUME THE DRIVER CALLS ALL STOPS
- ☐ GRASP COINS, PASSES, AND HANDLES?
- ☐ COMMUNICATE ADDRESSES, DESTINATION, AND TELEPHONE NUMBERS ON REQUEST?
- ☐ DEAL WITH UNEXPECTED SITUATIONS OR UNEXPECTED CHANGES IN ROUTE E.G., ROUTE CHANGE DUE TO ROAD CONSTRUCTION, REGULAR BUS STOP CLOSED?
- ☐ GO UP AND DOWN STEPS?

10. IF TRAINING FOR RIDING ON DART DIAL-A-RIDE BUS SYSTEM WERE AVAILABLE AT NO CHARGE, DO YOU THINK THAT YOU WOULD BENEFIT FROM RECEIVING THIS TRAINING?

☐ YES ☐ NO

I UNDERSTAND THAT THE PURPOSE OF COMPLETEING PART A IS THE FIRST STEP TO DETERMINE IF I AM FOR ADA/DISABLED TRANSIT SERVICE.

I CERTIFY BY MY SIGNATURE THAT I HAVE BEEN TRUTHFUL IN ANSWERING ALL QUESTIONS IN THE APPLICATION, AND THAT THE INFORMATION I HAVE PROVIDED IS CORRECT. I UNDERSTAND THAT PROVIDING FALSE INFORMATION COULD RESULT IN DENIAL OF SERVICE.

APPLICANTS SIGNATURE _____ DATE _____

DART DIAL-A-RIDE TRANSIT SYSTEM

1329 Waterloo Lane

Gardnerville, NV 89410

PHONE: (775) 783-6455 FAX: (775) 783-6457

DART DIAL-A-RIDE TRANSIT SYSTEM ELIGIBILITY APPLICATION

PART B

PROFESSIONAL VERIFICATION

Dear Qualified Professional:

The application form below contains questions to assist you in evaluating the applicant to determine their ADA status.

Please read the following ADA (Americans with Disabilities Act) definition of a person with a disability.

Any person with a disability who is unable, as a result of a physical or mental impairment to board, ride or disembark from an ADA accessible vehicle independently or complete transfers without the assistance of another individuals.

And/or

Any person with a disability who has a specific impairment that prevents them from traveling to and from a bus stop on the public bus system. Architectural and environmental barriers such as distance, terrain or weather do not, standing alone, from a basis for eligibility. However, consideration should be given to the interaction of environment conditions (terrain and weather) with the individual's impairment related condition.

_____

NAME OF APPLICANT

_____

P.O. BOX/ STREET ADDRESS CITY STATE ZIP CODE

Is the applicant eligible for ADA/ Disability status? ☐ YES ☐ NO

If no, please explain what additional services needed: For example a (PCA) Personal Care Assistant etc.. that will safely assist this ADA/ Disable Rider to board and exit transportation vehicles safely, please explain: _____

_____

_____ _____

PROFESSIONAL SIGNATURE DATE

_____ _____ _____

PRINTED NAME CERTIFICATION/LICENSURE PHONE NUMBER

CUSTOMER REGISTRATION FORM

LEGAL NAME (First/Last): _____

NICKNAME: _____ GENDER: ☐ MALE ☐ FEMALE ☐ OTHER

DATE OF BIRTH: _____ PHONE NUMBER: ( ) _____

PHYSICAL _____ MAILING _____

ADDRESS: _____ ADDRESS: _____

☐ NO CURRENT ADDRESS/RESIDENCE (IF DIFFERENT)

EMERGENCY CONTACT INFORMATION

NAME 1 (First/Last): _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK OR CELL PHONE: ( ) _____

ETHNICITY

☐ HISPANIC OR LATINO

☐ NON-HISPANIC OR LATINO

RACE

☐ WHITE / CAUCASIAN ☐ HISPANIC ☐ ASIAN

☐ AMERICAN INDIAN / ALASKAN NATIVE

☐ BLACK / AFRICAN AMERICAN ☐ OTHER

☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

If you do NOT speak English, what is you primary language? _____

FEDERAL POVERTY GUIDELINES

IS YOUR INCOME:

☐ At or Below Poverty

☐ Above Poverty

DO YOU:

1. LIVE ALONE?	☐ YES	☐ NO
2. LIVE WITH OTHERS?	☐ YES	☐ NO
3. HAVE A DISIBILITY?	☐ YES	☐ NO
4. CONSIDER YOURSELF FRAIL?	☐ YES	☐ NO

ARE YOU:

1. Unable To Leave Your Home Without Assistance?	☐ YES	☐ NO
2. A Veteran or Have Served In The Armed Forces?	☐ YES	☐ NO
3. Do you have a Disability or Disabilities?	☐ YES	☐ NO
4. A Caregiver?	☐ YES	☐ NO

If YES, for whom do you provide care?

☐ Spouse ☐ Parent ☐ Family Member ☐ Child, Age 0-18

☐ Adult Child, Age 18+ ☐ Other How many do you care for?

I was provided the Notice of Privacy Practices. ☐ YES ☐ NO

Are you on Medicaid through the State of Nevada? ☐ YES ☐ NO

Are you on Medicare? ☐ YES ☐ NO

If YES, which Parts? ☐ Part A: Hospital ☐ Part B: Medical ☐ Part C: HMO (Medicare Advantage)

☐ Part D: Prescriptions

CLIENT SIGNATURE _____ DATE _____

2nd Year CLIENT SIGNATURE _____ DATE _____

YOUR NAME (Please Print) _____ DATE _____

Activities of Daily Living (ADLs)	Instrumental Activities of Daily Living (IADLs)
☐ Bathe ☐ Eat ☐ Use the Bathroom	☐ Prepare Melas ☐ Manage Medication ☐ Do Laundry
☐ Get Dressed ☐ Maintain Continence	☐ Do Housework ☐ Use the Telephone ☐ Manage Money
☐ Transfer In or Out of a Bed or Chair	☐ Shop ☐ Use Transportation Services
☐ None - I CAN Perform these activities	☐ None - I CAN perform these activities

DETERMINE YOUR NUTRITIONAL HEALTH

Circle each that applies to you nutritional habits.	YES
1. I have an illness or condition that made me change the kind and/or amount of food I eat.	2 points
2. I eat fewer than 2 meals per day.	3 points
3. I eat few fruits or vegetables, or milk products.	2 points
4. I have 3 or more drinks of beer, liquor or wine almost every day.	2 points
5. I have tooth or mouth problems that make it hard for me to eat.	2 points
6. I don't always have enough money to buy the food I need.	4 points
7. I eat alone most of the time.	1 point
8. I take 3 or more different prescribed or over-the-counter drugs a day.	1 point
9. Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2 points
10. I am not always physically able to shop, cook and/or feed myself.	2 points
Total Your Nutritional Score	

If your score is....

0 - 2 Good! Recheck your nutritional score in 6 months

If it's.....

3 to 5 You are at moderate nutritional risk.

See what can be done to improve your eating habits and lifestyle. Refer to the attached handout for helpful tips. Recheck your nutritional score in 3 months.

6 or MORE You are at HIGH nutritional risk.

Bring this checklist the next time you see your Doctor, Dietitian or other qualified health or social service professional. Talk with them about any problems or concerns you may have. Ask for help to improve your nutritional health.

Douglas County Senior Services & Transportation
1329 Waterloo Lane
Gardnerville, NV 89410
Phone: (775) 783-6455 Fax: (775) 783-5500

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION

I Authorize Douglas County to use and disclose my medical records for the purposes of Treatment, Payment and Health Care Operations.

TREATMENT includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and constitutions with a between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician.

PAYMENT includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

HEALTH CARE OPERATIONS includes the necessary administrative and business functions of our office.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

You may review Douglas County's "Notice Of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent.

Because we have the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand that I have the right to revoke this Consent provided that I do so in writing, except to the Douglas County has already used or disclosed the information in reliance on this Consent and to examine the Douglas County's "Notice of Privacy Practices".

SIGNATURE OF PATIENT OR PERSON AUTHORIZED BY LAW _____ DATE _____

PRINTED NAME OF PATIENT OR PERSON AUTHORIZED BY LAW _____ DATE _____