If you are unable to travel on the RIPTA fixed route bus service due to a disability, you may be eligible to use the Rlde Program, a paratransit bus service. This allows you to schedule the specific bus rides you need instead of following a fixed route bus schedule and also allows you share a bus ride with other people who are traveling to a similar location and time.

**How do I know if I am eligible and how do I apply?**

**Step 1:** Please read the entire page one (1) to ensure you are eligible to apply for paratransit bus services with Rlde and read the instructions on how to complete the application process.

**Step 2:** Please read page two (2) completely and ensure that you complete each step outlined in the checklist. Rlde will only accept applications that are completed in full.

Once we receive the fully completed application, we will notify you within 21 (twenty-one) days. We thank you for your patience and hope you enjoy the ride.

**Questions about completing the application?**

Please email Rlde with questions at RIDE@RIPTA.com or call Rlde Monday - Friday 8:30 am - 4:30 pm at 401-461-9760, Option # 3.
Application for Paratransit Eligibility Certification

What is Paratransit?
The RIDE Program provides public transportation for people with disabilities who are unable to use RIPTA fixed route buses. If you are eligible, you will:

- Reserve the trips you need instead of following a fixed bus schedule; and
- Share the bus ride with other people who reserved the same trip.

How Is Eligibility Determined?
We do NOT base the decision automatically on symptoms, type of disability, use of a mobility aid, age, income, ability to drive, or access to private automobile transportation. We consider:

- Your functional ability; and
- Whether you are unable to travel on RIPTA fixed route service all or some of the time due to your disability; and
- Your effort and risk during such travel.

When Can I Use The RIDE Program?
We need to determine your eligibility BEFORE you can use RIDE. You cannot use RIDE during the application process.

We will try our best to make a decision within 21 days of receiving your ENTIRE COMPLETED APPLICATION. If we need more than 21 days, we will notify you and give you temporary permission to use the RIDE Program.

What Else Do I Need to Know?
We must receive the ENTIRE COMPLETED APPLICATION before we will process it.

Use the Part 1 Checklist to ensure that your application is completed properly.

DO NOT ALLOW A DOCTOR’S OFFICE TO FAX SECTIONS TO US. WE NO LONGER ACCEPT FAXED APPLICATIONS.

The application process:

- Is necessary to assess your eligibility;
- Does not guarantee that you will be certified eligible; and
- May include an interview and/or functional assessment.

After we complete the process, we will send a letter confirming or denying your application for certification. If you feel the decision is incorrect, you can file an appeal within 60 days by contacting Mark Therrien, Executive Director of Paratransit Services at the address below.

IMPORTANT NOTE ON PART 5

- This part must be filled out by a licensed health care provider whom you authorize to release your personal health information.
- Your information will be kept confidential and will not be shared with anyone outside the RIDE Program eligibility process and will not be released to any other party without your written permission to the maximum extent permissible under law.
- If you or another unqualified person fills out the information, it invalidates your application and may be fraud.
- If you skip any part, we will be unable to determine your eligibility.
- Do not allow a medical office to send copies or documents separately to RIDE.

How Do I Submit My Application?
Send the entire, complete application to RIDE Paratransit Eligibility through one of the following methods:

<table>
<thead>
<tr>
<th>U.S. Postal Service</th>
<th>Electronic Mail</th>
<th>In Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attn: RIDE Program</td>
<td><a href="mailto:RIDE@RIPTA.com">RIDE@RIPTA.com</a></td>
<td>Front Lobby</td>
</tr>
<tr>
<td>705 Elmwood Avenue</td>
<td></td>
<td>705 Elmwood Avenue</td>
</tr>
<tr>
<td>Providence, RI 02907</td>
<td></td>
<td>Providence, RI 02907</td>
</tr>
</tbody>
</table>
### Application for Paratransit Eligibility Certification

**Part 1: CHECKLIST**

After completing each step, check the box and write your initials.

1. **Confirm If I Live In the Service Area**
   - I dialed [401-461-9760, Option #3](tel:4014619760) to learn whether my address is inside or outside the RIDE Service Area. I understand that if I am eligible for paratransit service but live outside the service area, I will need another way to reach the pick-up points inside the service area, my trips must be within the service area, and I will need another way to travel from a RIDE drop-off point to my final destination.

<table>
<thead>
<tr>
<th>Inside service area</th>
<th>Outside service area</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. **Provide My Personal Information and Complete the Self-Assessment, pages 3 - 6**
   - I provided my current contact information.
   - I answered all the questions about my ability or inability to use the regular RITPA buses (“fixed route buses”).

3. **Authorize the Release of My Personal Health Information, page 7**
   - I provided the contact information for my licensed health care provider(s) and signed the authorization.

4. **Ask My Authorized Licensed Health Care Provider to Complete the Assessment and Provide Materials. Pages 8 - 9**
   - My authorized licensed health care provider(s) completed the assessment and returned all pages to me.
   - My authorized licensed health care provider(s) gave me at least one of the required supporting materials, which I attached to my application.

5. **Recent Photo of Myself**
   - Sending a photo may expedite the creation of a photo ID if you are certified eligible. If you email the photo, put your full name in the subject line.

   - [ ] I attached my photo to the application with a paperclip.
   - [ ] I emailed my photo to [RIDE@RIPTA.com](mailto:RIDE@RIPTA.com) (full name in the subject line).
   - [ ] I prefer to come to the RIDE location to have my photo taken.

6. **Review the Application, pages 3 - 9**
   - I made sure all questions have answers and all portions needing a signature are signed by the correct person.
   - I attached the materials from my authorized licensed health care provider.

7. **Make a Copy for My Records of pages 1 - 9**
   - I copied my completed application for my personal reference.

---

I understand this application is part of the process to determine eligibility for ADA paratransit service and that providing false information may result in penalties. I affirm that the information in this application is true to the best of my knowledge. I understand that RIDE will process my application in the date order received and that my application must be complete or it will be returned to me.

---

<table>
<thead>
<tr>
<th>Name of Applicant or Personal Representative</th>
<th>Signature of Applicant or Personal Representative</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Phone Number of Applicant or Personal Representative</th>
<th>Address of Applicant or Personal Representative</th>
</tr>
</thead>
</table>

The following Representative signed on my behalf:

- [ ] Parent (if applicant is a minor)
- [ ] Power of Attorney
- [ ] Legal Guardian
- [ ] As the Applicant, I signed on my own behalf
Part 2: IDENTIFICATION

Date: 

Is this a recertification? ☐ Yes ☐ No

If “YES” write the Expiration Date and Rlde ID #

<table>
<thead>
<tr>
<th>Expiration Date</th>
<th>Access ID#</th>
</tr>
</thead>
</table>

Name: 

Phone Numbers: 

Home Phone

Mobile Phone

My preferred phone number is: ☐ Home ☐ Mobile ☐ No Preference

Email: 

Date of Birth: 

Address: 

Apt/Unit: 

City, State, Zip: 

Provide information for the person we should contact in an emergency.

Emergency Contact Name: 

Relationship to Applicant: 

Phone Number(s): 

1. In what format would you like to receive information from Rlde?
   ☐ Large Font ☐ Audio Tape ☐ Email ☐ Braille ☐ Other answer: 

2. Where should we send future information? ☐ To me, the Applicant ☐ To the Designee listed below
   Name of Information Designee: 
   Address of Information Designee: 
   Email of Information Designee: 

Version 2, Effective 05/19/2022
Part 3: SELF-ASSESSMENT
Using fixed route service (regular RIPTA buses) does not automatically exclude you from paratransit eligibility.
1. I have the following diagnosed disability/disabilities:
   Do **NOT** list symptoms or mobility devices. List the name of your diagnosed disability/disabilities.

2. I am unable to use regular RIPTA buses all or some of the time without the assistance of another individual because:

3. My condition:
   (mark all that apply)
   - [ ] Is Constant
   - [ ] Changes Daily
   - [ ] Changes at Different Times of Day
   - [ ] Is in Remission
   - [ ] Not Applicable

4. I am **ABLE** to do this activity all or some of the time:
   (mark all that apply)
   - [ ] Get to the RIPTA bus stop
   - [ ] Wait alone at the RIPTA bus stop or curb
   - [ ] Board the RIPTA bus
   - [ ] Travel alone from a drop-off point to my destination
   - [ ] Transfer from one RIPTA bus to another
   - [ ] Ride the RIPTA bus
   - [ ] Exit the RIPTA bus
   - [ ] Navigate the RIPTA bus system
   - [ ] Navigate the RIPTA Transit Center
   - [ ] Find my way (visually / cognitively)
   - [ ] Sign my name
   - [ ] Use a phone to call for assistance
   - [ ] Give addresses upon request
   - [ ] Give phone numbers upon request
   - [ ] Travel alone as a passenger
   - [ ] Count money to pay for a purchase
   - [ ] Insert bills, coins, or cards into a machine
   - [ ] Recognize a destination or landmark
   - [ ] Ask for and follow oral instructions
   - [ ] Ask for and follow written instructions
   - [ ] None of the choices apply to me
5. I use the following mobility aids all or some of the time: (mark all that apply)
   - Cane
   - Manual Wheelchair
   - Crutches
   - Motorized Wheelchair or Scooter
   - Walker
   - Not Applicable
   - Prosthesis
   - Other answer:

   a) If you marked “Wheelchair or scooter,” provide the details below. Otherwise, mark “Not Applicable.”

      Combined weight of applicant and wheelchair/scooter

      For Ride information purposes only. Will not be used to determine eligibility.

      Ride will transport an 800-pound wheelchair/passenger combination, but not a combination exceeding 800 pounds. Per Federal Transit Administration regulations operator may deny transportation if carrying the wheelchair and its occupant would be inconsistent with legitimate safety requirements.

6. I am **ABLE** to navigate this situation all or some of the time: (mark all that apply)
   - Unpaved paths
   - Places without curb cuts
   - Snow on sidewalks or streets
   - Busy streets and intersections
   - Steep sidewalks or streets
   - None of the choices apply to me
   - RIPTA bus stops

7. I use these modes of transport regularly: (mark all that apply)
   - I do not use other modes of transport regularly
   - Ambulance
   - Friend/relative gives me a ride
   - Agency-sponsored ride from:
   - Personal vehicle (car)
   - Walking (with or without a mobility aid)
   - Wheelchair or scooter
   - Other answer:

For Ride information purposes only. Will not be used to determine eligibility.
8. I can travel these distances on my own in **MILD** weather: (mark all that apply)

<table>
<thead>
<tr>
<th>Distance</th>
<th>Walking WITHOUT mobility device</th>
<th>Walking with a mobility device</th>
<th>Using a Manual Wheelchair</th>
<th>Not at All</th>
</tr>
</thead>
<tbody>
<tr>
<td>To/from the bus stop nearest to my residence</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>To the curb only</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>1 block</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3 blocks (1/4 mile)</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>6 blocks (1/2 mile)</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>9 blocks (3/4 mile)</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

9. The following weather conditions will affect my answers to question #8: (mark all that apply)

- □ Not applicable
- □ Ice
- □ Snow accumulation of 2 inches+
- □ Temperature above 80°F
- □ Rainfall of ½ inch+ per hour
- □ Temperature below 30°F
- □ Sustained wind speeds of 25 miles+ per hour
- □ Other answer:

10. I can reasonably travel this distance under optimal conditions in an accessible area on my own:

   *Distance in Feet, Blocks, or Miles*

11. My ability to cross streets is as follows: (mark all that apply)

<table>
<thead>
<tr>
<th>Ability</th>
<th>Yes with Help</th>
<th>Yes on My Own</th>
<th>Sometimes on My Own</th>
<th>No</th>
<th>Other Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can cross a 2-lane street</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>I can cross a 4-lane highway with traffic lights</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

12. I use the following some or all of the time:

- □ Personal Care Attendant designated to assist me with one or more life activities regularly
- □ Service Animal trained to assist me
- □ Not applicable
Part 4: AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Print Applicant’s Name and Date of Birth Here

I authorize the provider(s) named here, his/her officers, employees, agents, contractors, members, directors, shareholders or affiliates entrusted with handling medical records, to disclose to RIdE all of the protected health information relating to me that is reasonably necessary for the provider to fully and accurately complete Part 5 of this application.

-1- Name of Provider:_________________________
Office or Facility Address:______________________
Office Phone:__________________________

-2- Name of Provider:_________________________
Office or Facility Address:______________________
Office Phone:__________________________

-3- Name of Provider:_________________________
Office or Facility Address:______________________
Office Phone:__________________________

This authorization shall remain in effect until my eligibility for RIdE paratransit service is finally determined or 60 days from the date of the authorization, whichever occurs first. I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the persons named above. I understand that the revocation of this authorization is not effective to the extent that the name provider has relied upon it for the use or disclosure of the Protected Health Information prior to receiving my written revocation notice.

I understand that any Protected Health Information disclosed pursuant to this Authorization to an individual or entity that is not covered by state and federal privacy laws and regulations may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I acknowledge that the named persons will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I sign this Authorization.

Printed Name_________________________Signature_________________________Date_________________________

The following Representative signed on my behalf:

☐ Parent (if applicant is a minor) ☐ Power of Attorney ☐ Legal Guardian

☐ As the Applicant, I signed on my own behalf
Part 5: HEALTH CARE PROVIDER ASSESSMENT AND VERIFICATION

ATTENTION APPLICANTS: A LICENSED / CERTIFIED PROFESSIONAL OR DISABILITY SERVICE PROVIDER WHO IS QUALIFIED TO RENDER THE SPECIFIC DIAGNOSES AND ASSESSMENTS MUST COMPLETE THIS PART. YOU, OR YOUR REPRESENTATIVE, ARE RESPONSIBLE FOR GETTING THE APPLICATION TO THE PROVIDER/PROFESSIONAL AND COLLECTING THE COMPLETED APPLICATION AND SUPPORTING MATERIAL.

**Attention Medical Professionals and Disability Service Providers:**
The Applicant must be your current patient or client. The Applicant must provide authorization for you to release his/her Protected Health Information (Part 4).

Your patient/client is applying for eligibility certification to use the tax-supported paratransit service through the RIdE Program. Paratransit eligibility is based on whether a person, due to his/her disability, is unable to use the regular ADA compliant and accessible RIPTA bus system (fixed route).

Failure to provide the information in this Part will prevent or delay processing of the patient/client’s application for eligibility certification.

**Do not detach any part of the application. Return the entire application and materials to the patient/client or representative (parent, legal guardian, power of attorney).**

**Do not fax copies or materials to RIdE. Faxes are no longer accepted for eligibility applications.**

**All Protected Health Information will be kept confidential.**

1. I am a licensed: (check all that apply)
   - [ ] Medical Doctor (MD or DO)
   - [ ] Nurse Practitioner (ARNP)
   - [ ] Psychologist (Ph. D.)
   - [ ] Physician’s Assistant
   - [ ] Psychiatrist (MD or DO)
   - [ ] Optometrist or Ophthalmologist
   - [ ] Licensed Mental Health Professional
   - [ ] Physical or Occupational Therapist
   - [ ] MDS Nurse (Skilled Nursing Facilities Only)
   - [ ] Certified Orientation & Mobility Specialist
   - [ ] Certified Rehabilitation Counselor

2. Licensed Professional Identification (please print clearly):

   Name: ____________________________
   License #: ____________________________ State: ____________________________
   
   State Certification Number or License Number

   Contact: ____________________________
   Phone Number: ____________________________ Business Address: ____________________________ Email: ____________________________

3. Patient/Client Identification (please print clearly)

   Name: ____________________________
   Date of Birth: ____________________________
Application for Paratransit Eligibility Certification

4. List the condition that would prevent the Patient/Client from independently getting to or from or riding on an accessible RIPTA bus equipped with a ramp and kneeler. One diagnosis is required, but additional fields are available.

<table>
<thead>
<tr>
<th>#1 - Diagnosis/Condition (not symptoms)</th>
<th>Degree (mark all that apply)</th>
<th>Status (mark all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Mild</td>
<td>☐ Active</td>
</tr>
<tr>
<td></td>
<td>☐ Moderate</td>
<td>☐ In Remission</td>
</tr>
<tr>
<td></td>
<td>☐ Severe</td>
<td>☐ Controlled w/ Medication</td>
</tr>
<tr>
<td></td>
<td>☐ Episodic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Permanent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Temporary</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#2 - Diagnosis/Condition (not symptoms)</th>
<th>Degree (mark all that apply)</th>
<th>Status (mark all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Mild</td>
<td>☐ Active</td>
</tr>
<tr>
<td></td>
<td>☐ Moderate</td>
<td>☐ In Remission</td>
</tr>
<tr>
<td></td>
<td>☐ Severe</td>
<td>☐ Controlled w/ Medication</td>
</tr>
<tr>
<td></td>
<td>☐ Episodic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Permanent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Temporary</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#3 - Diagnosis/Condition (not symptoms)</th>
<th>Degree (mark all that apply)</th>
<th>Status (mark all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Mild</td>
<td>☐ Active</td>
</tr>
<tr>
<td></td>
<td>☐ Moderate</td>
<td>☐ In Remission</td>
</tr>
<tr>
<td></td>
<td>☐ Severe</td>
<td>☐ Controlled w/ Medication</td>
</tr>
<tr>
<td></td>
<td>☐ Episodic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Permanent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Temporary</td>
<td></td>
</tr>
</tbody>
</table>

5. I have read Part 3 and agree with the Patient/Client’s self-assessment.
☐ Yes   ☐ No   ☐ Somewhat

If NO or SOMEWHAT, explain below:

6. I am providing the Patient/Client with this material to submit with his/her Application as required by RIde (provide at least ONE of the following items; mark each that you provided).

<table>
<thead>
<tr>
<th>Physical Mobility</th>
<th>Cognitive, Mental Health, or Neurological</th>
<th>Sensory Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Current Patient Care plan</td>
<td>☐ Current GAF score</td>
<td>☐ Visual acuity</td>
</tr>
<tr>
<td>☐ Current Therapy plan (PT or OT)</td>
<td>☐ Current Adaptive Functioning score</td>
<td>☐ Hearing acuity</td>
</tr>
<tr>
<td></td>
<td>☐ Current IQ score</td>
<td></td>
</tr>
</tbody>
</table>

7. My signature attests to the following:
   - I am certified or licensed as a disability service provider or medical professional.
   - The patient/client is currently under my care and I am authorized to release his/her Protected Health Information to degree relevant for this eligibility application.
   - I understand that the information I provide is necessary to corroborate a patient/client’s application for eligibility for paratransit service under the "Americans With Disabilities Act of 1990 "(ADA) and its regulations, Section 37.123(e), within the designated paratransit service areas of RIde.
   - My statements are true and based on legitimate records, diagnosis, and assessment.

Printed Name ___________________________ Signature ___________________________ Date ________________

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