GALAVAN APPLICANT INTAKE FORM

Your answers to these questions do not affect your eligibility criteria for Galavan services. This data is collected for HRDC's internal statistics and reporting to funding sources. Your thoroughness is greatly appreciated!

Name _____ Date _____

Phone _____ DOB _____

Street Address _____ Zip _____

Mailing Address _____ Zip _____

Emergency Contact/Phone _____

Gender: ☐ M ☐ F Veteran: ☐ Y ☐ N Disabled: ☐ Y ☐ N

If you are a disabled senior, you will receive all of the benefits of the paratransit service if you fill out the paratransit application after this page. If you do not, you will not be eligible for weekend and other paratransit specific rides.

Health Insurance: ☐ Medicaid ☐ Medicare ☐ Private ☐ None

Do you use a:
☐ power chair
☐ wheelchair
☐ walker
☐ none of the above

Marital Status *Please select the option that best describes your marital status:*
☐ Single ☐ Domestic partner ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Family Type *Please select the option that best describes your family:*
☐ Single person ☐ Single parent – female ☐ Single parent – male
☐ Two parent household ☐ Two or more adults (no children) ☐ Grandparent(s) raising child(ren)
☐ Mixed adults with children ☐ Extended family ☐ Other

Income Estimated gross household income: $ _____ / ☐ week ☐ month ☐ year *(check one)*

Employment Are you employed? ☐ Yes ☐ No ☐ Retired ☐ Unable to work (disabled receiving SSI/SSD)
IF NO, do you have a positive work history and/or skills? ☐ Yes ☐ No
If **Yes**, are you employed ☐ Full-time (32+ hrs/wk) ☐ Part-time
If **Yes**, is your hourly wage ☐ Minimum Wage ☐ above Minimum Wage
If **Yes**, does your employer provide benefits? ☐ Yes ☐ No

Housing Status *Please select the option that best describes your current living situation:*
☐ Homeless ☐ Substandard or unsafe housing ☐ Living with relatives or friends (temporary)
☐ Home ownership ☐ Emergency/temporary shelter _____ ☐ Transitional housing _____
☐ **Subsidized** unaffordable rental (*facing eviction?* ☐) ☐ **Non-Subsidized** unaffordable rental (*facing eviction?* ☐)
☐ Unaffordable home (*facing foreclosure?* ☐) ☐ **Subsidized** safe/secure housing ☐ **Non-Subsidized** safe/secure housing
In addition.... ☐ Are you using a **Section 8 Voucher** to pay rent?

Education Level *Please select your highest level of education:*
☐ None ☐ 1st-8th ☐ 9th-12th non-graduate ☐ GED ☐ HS diploma ☐ Vocational / certificate training / some college
☐ College – Associates or Bachelors ☐ College – Masters or Doctorate

Transportation *Please select the option that best describes your access to transportation:*
☐ No vehicle or access to public transportation ☐ Rarely have transportation needs met
☐ Some transportation needs are met ☐ Most transportation needs are met ☐ Transportation needs are always met

Childcare *Please select the option that best describes your childcare situation:* ☐ **Not applicable**
Child/Children...
☐ enrolled in *unlicensed* childcare ☐ not enrolled in any childcare ☐ on waiting list for childcare
☐ provided childcare by family/friend ☐ enrolled in licensed *subsidized* childcare – *limited choice*
☐ enrolled in licensed *subsidized* childcare – *of own choice* ☐ enrolled in licensed *non-subsidized* childcare – *of own choice*

I authorize HRDC IX, Inc. to enter the information contained on this application in electronic database(s) for purposes of tracking services provided to my household, and reporting to federal, state, or other funding sources.

_____
Signature Date

☐ Intake by phone Intake completed by: _____ Client ID # _____ ☐ Head of Household ☐ CAP60 v3_07182013

Streamline
A PROGRAM OF HRDC
Catch the Current!

GALAVAN
A PROGRAM OF HRDC
406-587-2434

32 South Tracy Ave | Bozeman, MT 59715

(406) 587.2434 | Fax (406) 551-9078
www.StreamlineBus.com

Paratransit Application

1. Eligibility Questionnaire

This form must be completed by the applicant or someone authorized to sign on the applicant's behalf.

2. Professional Verification Form

All applicants must sign the Authorization for the Release of Information included in part 2, page 1. The rest of the form must be completed by a professional who is familiar with the applicant's condition and qualified to respond (see right).

3. Submit Both Forms Together

Submit both the **Yellow Eligibility Application** and the **Green Professional Verification** together. All applications will be processed within 21 calendar days of receipt of the completed packet and the applicant will be notified in writing of Galavan's determination of eligibility.

List of Qualified Professionals:

- Physician or Psychiatrist
- Physical Therapist
- Physician Assistant
- Licensed Clinical Social Worker (LCSW)(LCPC)
- Occupational Therapist
- Registered Nurse or Nurse Practitioner
- Psychologist
- Certified Orientation and Mobility Specialist
- Speech/Language Pathologist

Galavan recognizes that many professionals work with clients that are disabled and the list above is not meant to exclude those professionals. In general, this will require completing a multi-year degree program and/or being licensed by the State of Montana. A primary care physician is often able to adequately complete this form. You do not need to visit a specialist.

Avoid Delays in Application Process

- All pages for both forms must be submitted
- Check that all questions have been answered
- Make sure all needed signatures are present
- Double check the professional credential section is complete

An incomplete application will be returned to the applicant one (1) time with a notice of what is missing. If it is returned to Galavan Paratransit incomplete a second time, the applicant will be sent a new blank application to complete.

In-Person Assessment

The eligibility of most applicants can be determined by the forms submitted to Galavan staff. However, there may be cases where Galavan requests to conduct an in-person functional assessment of an applicant's disability. This assessment may include, but is not limited to:

- A conversation about the applicant's mobility
- Reading a bus schedule to plan out a bus trip
- Taking a short walk
- Practice boarding an actual bus

If an in-person assessment is requested, your application will still be processed within 21 calendar days of receipt. Transportation will be provided to an in-person assessment if necessary.

Before you continue:

_____ Please initial here if you are a senior (60+) without a disability and do NOT wish to be considered for paratransit services. OR please complete the remainder of the application.

App Received:_____

Approved:_____

Expiration Date:_____

1 Part 1 Eligibility Application

Complete the entire application. Incomplete applications will be returned.

Is this a new application, or a recertification? ☐ New ☐ Recertification

Applicant Information		
First Name	Last Name	Middle Initial
Street Address		Apt. #
City	State	Zip Code
Is this an apartment complex, mobile home park, or facility? ☐ Yes ☐ No	Name of complex or facility	
Home Phone	Mobile Phone	Email Address
Preferred Notification Method ☐ Voice Call ☐ Email	Gender ☐ Male ☐ Female ☐ Non-Binary ☐ Prefer not to say	
Date of Birth (mm/dd/yyyy)	Primary Language ☐ English ☐ Other _____	

☐ **Check this box if someone other than the applicant is completing this form and provide the following information**

Legal Guardian Information		
First Name	Last Name	Middle Initial
Street Address		Apartment #
City	State	Zip Code
Home Phone	Mobile Phone	Relationship to Applicant (Family Member, Case Worker, etc.)

In case of emergency, who should we contact?	Who is authorized to contact Galavan on your behalf?
Emergency Contact Name	Contact Name 1 (Individual or Organization)
Primary Phone ( )	Phone ( )
Secondary Phone ( )	Contact Name 2 (Individual or Organization)
Relationship	Phone ( )

A General Information

How long would you like to use the service? ☐ Temporarily ☐ Permanently
(Recertification is required every 2 years)

What is your current primary transportation option?

☐ Walking ☐ Taxi ☐ Galavan Paratransit
☐ Drive myself ☐ Fixed Route Bus ☐ Other, specify:_____
☐ Ride with somebody ☐ Bicycle

Can you use the fixed route bus without someone else's help?

☐ Yes, I currently ride the Fixed Route Buses ☐ No, I have never ridden.
☐ I only ride with assistance from others. ☐ I do not ride anymore because:_____
☐ I only ride when the bus stops are accessible.

Galavan provides free, in-person training to help you learn to ride our Fixed Route Buses. Would you be interested in this as an alternative?

☐ No ☐ Yes ☐ Possibly, please contact me.

Do you require a Personal Care Attendant to travel with you?

☐ No ☐ Yes ☐ Sometimes, specify:_____

Do you travel with a Service Animal? ☐ No ☐ Yes, Type: _____

B Required Assistance

What mobility device(s) will you be using? (Note: Larger mobility devices and devices that exceed 600 pounds when occupied may exceed equipment transport capacity.)

☐ Cane ☐ White Cane ☐ Manual Wheelchair
☐ Crutches ☐ Prosthesis ☐ Powered Wheelchair or Scooter
☐ Walker ☐ Portable Oxygen ☐ No aid required

What is your estimated bodyweight? _____ lbs.
(For mobility device users)

Are you able to complete the following tasks without assistance from another person?
Check a box for each question. If you answer sometimes for any questions please explain.

A. Get to/from a bus stop?	☐ Always	☐ Never	☐ Sometimes
B. Walk or travel using a mobility device for 3 blocks?	☐ Always	☐ Never	☐ Sometimes
C. Get on/off a fixed route bus **without** using the lift or ramp?	☐ Always	☐ Never	☐ Sometimes
D. Get on/off a fixed route bus using the lift or ramp?	☐ Always	☐ Never	☐ Sometimes
E. Climb three 10-inch steps?	☐ Always	☐ Never	☐ Sometimes
F. Wait at a bus stop while standing for 15 minutes?	☐ Always	☐ Never	☐ Sometimes
G. Wait at a bus stop while sitting for 15 minutes?	☐ Always	☐ Never	☐ Sometimes
H. Maintain your balance entering, exiting, and riding a fixed route bus?	☐ Always	☐ Never	☐ Sometimes
I. Understand and follow verbal directions?	☐ Always	☐ Never	☐ Sometimes
J. Recognize correct stops and landmarks to complete a trip?	☐ Always	☐ Never	☐ Sometimes
K. Hear stops announced by the operator?	☐ Always	☐ Never	☐ Sometimes
L. Read and follow informational signs?	☐ Always	☐ Never	☐ Sometimes
M. Plan a trip using a bus schedule?	☐ Always	☐ Never	☐ Sometimes
N. Clearly communicate information about yourself?	☐ Always	☐ Never	☐ Sometimes

Please explain any boxes checked Sometimes: _____
_____
_____
_____

C Disability Information

These questions help describe your disability and how it may impact you.

What is your disability? _____
_____
_____

Is your disability:
☐ Permanent ☐ Stable ☐ Progressive ☐ Temporary, how long? Months_____Years_____

Explain how your disability prevents you from the following:

Please provide a complete and specific answer. Attach an additional page if needed.

- Getting on or off a lift/ramp equipped Fixed Route Bus; and/or
- Getting to or from a bus stop; and/or
- Successfully completing a bus trip

_____
_____
_____
_____
_____
_____
_____
_____

How far can you travel on level ground? (With your mobility aid, if any.)

☐ Less than one block ☐ Two blocks ☐ Three blocks ☐ Four blocks or more

Can you, with a mobility aid if needed:

Self-ambulate from your threshold to curbside?	☐ Yes ☐ No
Wait at the street curb for a ride?	☐ Yes ☐ No
Wait at the front door/lobby for your ride?	☐ Yes ☐ No

(Note: Galavan operators are not allowed to cross the outer threshold of any residence, facility or business.)

Does your disability prevent you from using Fixed Route service seasonally?

☐ No, my inability to ride is not weather related.
☐ Yes, I can only ride Fixed Route Buses in the summer.
☐ Yes, I can only ride Fixed Route Buses in the winter.

Does your disability change daily in ways that could disrupt your ability to use Fixed Route Bus service?

☐ No ☐ Yes, please explain: _____
_____

Please list three trips you frequently take:

	Starting Address	Ending Address
1.	_____	_____
2.	_____	_____
3.	_____	_____

D Application Signature

I understand that the purpose of this application is to determine if the applicant is eligible to use ADA Paratransit Service. I certify that the information provided in this application is true and correct. **I understand that falsification of information could result in the denial of ADA Paratransit services as well as a penalty under the law.** I agree to notify Galavan if my circumstances change and I no longer need to use ADA Paratransit Services. I understand that I am responsible for authorizing a Professional Verification of my condition(s). I also understand that a follow-up conversation, an informational meeting or functional assessment by a professional selected by Galavan may be requested.

Applicant or Guardian Signature: _____

Date: _____

The following pages must be sent to your Health Care Provider *after* you complete section 2, page 1, Information Release.

Part 1 Completed.

2

Part 2 Galavan Paratransit

Professional Verification

Complete the entire application. Incomplete applications will be returned.

Information Release

Medical Information / HIPAA Authorization

I, _____ authorize the healthcare provider (listed below), and their office completing this application to release to Galavan any protected health information about my disability in order to verify my eligibility for Paratransit service. I also authorize the release of further information should it be needed for this application for a period of 60 days from the date of my signature on this application unless revoked in writing.

Applicant Signature	Date
Applicant Name (printed)	Date of Birth
Applicant Address	Applicant Phone #

Your Health Care Provider

Health Care Provider		
Provider	**Profession**	
Address	**Phone**	**Fax**

The following pages must be filled out by your Health Care Provider.

32 South Tracy Ave | Bozeman, MT 59715

(406) 587.2434 | Fax (406) 551-9078
www.StreamlineBus.com

Dear Healthcare Professional:

The patient listed on the accompanying release form is applying for Galavan Paratransit Service. The information you provide in answering the questions on the enclosed questionnaire will aid Galavan in making a Paratransit eligibility determination. Please keep in mind this document is time sensitive. Because demand for this service is high, qualification criteria are stringent. For the benefit of the applicant please answer all of the questions completely and accurately. Please return completed questionnaires to the applicant so that they can return the completed packet to Galavan.

In accordance with Americans with Disabilities Act (ADA) guidelines, Paratransit service is available only for persons who have disabilities that prevent them from traveling on Fixed Route Buses. The individual could be prevented by inabilities to independently get to and from a bus stop, on or off a bus, or to successfully navigate to a destination.

Please keep in mind that ADA Paratransit eligibility is not based on age, a medical condition, the inability to drive, or the use of a particular mobility aid. The severity of a disability does not confer eligibility. Comfort and convenience are not factors. ADA Paratransit eligibility is based on the EFFECT that a disability has on your client's ability to use the regular Streamline lift or ramp equipped Fixed Route Bus system.

All information provided will remain confidential. If you have any questions, please call (406) 587-2434.

Thank you for your assistance,

Galavan Paratransit Services

A General Disability Questions

Describe the diagnosed disability or disabilities that you are currently treating this individual for?

_____
_____
_____
_____
_____
_____

Check all that apply

Is the patient's disability:
☐ Permanent ☐ Stable ☐ Progressive ☐ Temporary - How long? Months_____Years____

Does your client's disability:

☐ Affect mobility ☐ Affect judgment ☐ Require use of a mobility aid

☐ Require them to have a PCA when traveling outside their residence (checking this box means that the client cannot travel safely without a PCA)

Can your client:

A. Walk two blocks (600 feet) with their mobility aid?	☐ Yes ☐ No
B. Climb three standard steps without assistance?	☐Yes ☐ No
C. Stand without support for 15 minutes?	☐ Yes ☐ No
D. Walk or stand without debilitating pain or discomfort?	☐ Yes ☐ No
E. Board or de-board a fixed route bus equipped with a lift or ramp?	☐ Yes ☐ No
F. Recognize correct stops and landmarks to complete a trip?	☐ Yes ☐No
G. Hear and understand verbal information?	☐ Yes ☐ No
H. Read and understand informational signs?	☐ Yes ☐No
I. Plan a trip using public transportation?	☐ Yes ☐ No
J. Communicate information about themselves?	☐Yes ☐ No

B Disability Specific Questions

ICD 11/DSM Code for the condition(s) you are treating: _____

WHODAS Score (if citing a cognitive or psychological disorder): _____

Please only complete those questions that apply to the applicant for this section.

Does the applicant experience seizures? ☐ No ☐ Yes

Is the applicant's judgment impaired? ☐ No ☐ Yes

Does this condition affect the applicant's ability to move independently outside their residence or a supervised environment? ☐ No ☐ Yes

Does the applicant experience any hallucinations, delusions, or disassociation? ☐ No ☐ Yes

Does this prevent the applicant from being oriented to person, place, & time? ☐ No ☐ Yes

Please describe any triggers that may cause psychological disorders to manifest.

_____
_____
_____
_____
_____
_____
_____

Please describe the functional limitations caused by this impairment.

_____
_____
_____
_____
_____
_____
_____

C Mobility and Safety Questions

Does the applicant have a visual impairment that affects their ability to move about in the environment?

☐ No ☐ Yes If yes, please explain: _____

_____

_____

_____

_____

_____

Has the applicant received any orientation & mobility training?

☐ No ☐ Yes If yes, please explain: _____

_____

_____

_____

_____

Please list any side effects of medication the applicant experiences that could affect transporting them safely. _____

_____

_____

_____

_____

_____

Would you like to add any additional comments on the functional ability of the applicant?

_____

_____

_____

_____

_____

_____

D Provider Affirmation

Provider Information		
Address	Phone	Fax
City	State	Zip code
Provider UPIN # or Tax ID	Employer / Agency	

Provider Signature and Affirmation

I am a licensed medical provider or qualified service provider and certify that the above mentioned individual has the disability and limitations indicated above.

_____ _____

Provider Signature Date

_____

Provider Name (printed)

Part 2 Completed.

3

Part 3 Galavan Paratransit

Submit Both Forms Together

Complete the entire application. Incomplete applications will be returned.

Make sure all questions have been answered, and required signatures are in place.

Submit both the YELLOW Eligibility Application and the GREEN Professional Verification Form.

Mail to: **Galavan Paratransit**
32 South Tracy Ave
Bozeman, MT 59715
Fax #: (406) 551-9078

You may also submit all forms in person at the address above, M-F, 8:00 am – 4:00 pm.

All applications will be processed within 21 calendar days of receipt of a completed packet and the applicants will be notified in writing of Galavan's determination of eligibility.

In-Person Assessment

You will be contacted if an in-person assessment is required. If an in-person assessment is requested, your application will still be processed within 21 calendar days of receipt. Transportation will be provided to an in-person assessment if necessary.

Thank you for completing the Paratransit Application. Please make sure that all questions have been answered, signatures gathered, and both forms are included in your submission. We look forward to serving you.