COMPLETED APPLICATIONS MAY BE SENT TO:
NORTH COUNTY TRANSIT – SAN DIEGO RAILROAD (NCTD)
810 MISSION AVENUE, OCEANSIDE, CA 92054

NCTD Application Guide for LIFT Paratransit

Thank you for inquiring about eligibility for North County Transit – San Diego Railroad's (NCTD) LIFT Paratransit Service. NCTD provides multiple public transportation services for people with disabilities. Eligibility for these services is based on how the disability affects your functional ability to use NCTD's fixed-route bus and rail service. All NCTD buses and trains are accessible for people with disabilities and include features such as low floors, level boarding, lifts/ramps, audio announcements, designated priority seating areas for people with disabilities, enhanced signage, kneeling buses, and handrails.

NCTD provides a Reduced Fare Program for eligible seniors, people with disabilities and those on Medicare (S/D/M Program). This program provides discounted fares on NCTD's fixed-route buses and rail service and is the primary program used by most customers with disabilities in the North County region. Eligible customers can travel on accessible buses and trains at a reduced fare on daily, monthly and 30-day passes. This program is available for people with disabilities who are functionally able to use the fixed-route bus and rail systems as their primary travel option. For more information on the S/D/M Program or to obtain an application, please visit:

www.gonctd.com/reduced-fare-eligibility
NCTD (760) 966-6500

NCTD also provides LIFT Paratransit Service (LIFT). Under 49 CFR §37.121 NCTD is mandated to provide paratransit to individuals with disabilities that is comparable to the level of service provided to individuals without disabilities who use the fixed-route bus or rail system. If you are functionally unable to use the fixed-route bus and rail service, you may be eligible for LIFT. LIFT is a shared-ride paratransit service that is available to qualified applicants whose physical or cognitive limitations prevent them from utilizing NCTD's regular fixed-route bus and rail service. You may request LIFT trips during the same hours of the day and days of the week within a ¾ mile zone of BREEZE fixed-route bus and SPRINTER rail service. LIFT travel time is comparable to the level of service and ride time provided on NCTD's fixed-route bus and rail service.

LIFT ELIGIBILITY IS NOT BASED ON AGE, MEDICAL DIAGNOSIS, A REVOKED DRIVERS LICENSE, FINANCIAL STATUS, OR BEING A U.S. MILITARY VETERAN. To be eligible for LIFT, you must have a disability (i.e., physical, mental and/or visual) that prevents you from using NCTD's fixed-route bus or rail service. People with disabilities who can independently use NCTD's fixed-route bus or rail service may not qualify for LIFT service.

NCTD uses an independent third-party contractor, ADARide, to provide eligibility determinations for potential LIFT customers. To qualify for LIFT, you must submit an application for NCTD LIFT Paratransit Service. After receipt and review of an application an in-person functional assessment will be scheduled at the NCTD Escondido Paratransit Assessment Center, located at the Escondido Transit Center in Escondido, CA. If you are unable to get to the in-person assessment with your own transportation, NCTD will provide a ride at no cost. Photo identification will be needed to verify your identity for the in-person assessment. The assessment itself is expected to last approximately one hour; however, you should anticipate the total time for the assessment and travel time to and from the assessment facility to be approximately 2 to 3 hours.

LIFT eligibility may be granted for up to 3 years. Customers desiring to continue LIFT service after the eligibility expiration date must reapply and complete the eligibility process prior to their eligibility expiration date in order to prevent a lapse in LIFT service. Please allow at least 21 days to complete the process.

You will be notified by mail regarding your eligibility determination within 21 calendar days after your complete application has been submitted, or after the functional assessment is completed. If a determination is not provided to you within 21 calendar days, you will be granted presumptive eligibility until a final determination has been made. If found to be eligible for LIFT service, you will receive a LIFT identification number and a Rider's Guide describing the LIFT service and booking process in more detail. Your eligibility determination letter will have more details regarding the NCTD LIFT Appeals process.

For additional information or assistance, please contact ADARide at (760) 966-6645, or review the NCTD website at www.gonctd.com/lift.

APPLICATION FOR NCTD LIFT PARATRANSIT SERVICE

PERSONAL INFORMATION

First Name _____ Middle Initial _____ Last Name _____

Date of Birth _____ Gender ☐ Male ☐ Female ☐ Other

Is this a new application or a recertification?

☐ New ☐ Recertification

If this is a recertification, please provide your Trapeze number: _____

HOME ADDRESS

Number and Street _____ Apt # _____

City _____ State _____ Zip Code _____

MAILING ADDRESS (If Mailing Address is different from Home Address, please provide below)

Number and Street _____ Apt # _____

City _____ State _____ Zip Code _____

CONTACT INFORMATION

Home Phone _____

Cell Phone _____

Email Address _____

Desired notification format:

☐ Audio
☐ Electronic file (PDF
☐ Large Print
☐ Braille
☐ Other

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EMERGENCY CONTACT

Please give us the name and phone number of a person we can call in case of emergency or if we are unable to reach you at your regular number:

First and Last Name _____

Home Phone _____

Cell Phone _____

Relationship _____

Please provide your Compass Card Number (if you do not have a Compass Card, please skip to the next question)

_____

Please provide your Medi-Cal Number to assist NCTD in recovering costs related to your non-emergency medical transportation trips (if you are not enrolled in Medi-Cal, please skip to the next question)

_____

If Medi-Cal, please provide your Managed Care Provider:

- ☐ Aetna Better Health of California
- ☐ BCBS of California Promise Health Plan
- ☐ Community Health Group Partnership Plan
- ☐ Health Net Community Solutions, Inc.
- ☐ Kaiser Permanente
- ☐ Molina Healthcare of California Partner Plan, Inc.
- ☐ UnitedHealthcare Community Plan

Do you require TDD services?

☐ Yes ☐ No

Do you live in an assisted living facility or nursing facility?

☐ Yes ☐ No

Do you need a Personal Care Attendant (PCA)?

☐ Yes ☐ No

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DISABILITY/HEALTH CONDITION INFORMATION

Please describe the disability or health condition which prevents you from using fixed-route bus service:

_____

_____

_____

_____

_____

Is this a temporary disability or health condition?

☐ Yes ☐ No

If yes, how long do you expect your disability to prevent you from using fixed route buses?

Months: _____

Are you currently receiving any treatment?

☐ Yes ☐ No

If yes, check what treatment(s) apply to you:

☐ Non-weight Bearing Immobilization
☐ Physical Therapy
☐ Chemotherapy
☐ Radiation Therapy
☐ Surgery
☐ Mobility Training
☐ Convalescence
☐ Dialysis
☐ Psychotherapy
☐ Medications
☐ Rehabilitation Program
☐ Non-Walking Cast
☐ Weight Bearing Immobilization
☐ Other:

If you are currently receiving treatment, how long is the treatment expected to last?

☐ 0 – 3 months
☐ 3 – 6 months
☐ 6 – 9 months
☐ 9 – 12 months
☐ Over a year

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Describe any side-effects you are currently experiencing from the medication/treatment you are receiving:

HEALTHCARE PROVIDER (Optional, you may leave blank)

Primary Provider's Name _____

Institution/Facility/Agency Name _____

Number and Street _____

City _____ State _____ Zip Code _____

Office Phone _____

Cell Phone _____

Email Address _____

Specialization _____

FUNCTIONAL TRANSIT SKILLS AND ABILITIES

Please read the following statements and check the one that best describes your ability:

☐ I am able to ride the transit system independently.
☐ I believe I can ride the transit system if someone taught me how to ride.
☐ I can use the transit system for some trips but not others.
☐ I have a temporary disability and will only need LIFT until I recover.
☐ I am not able to use the transit system by myself.

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Which if the following can you perform without the help of someone else:

Ask for and understand written or spoken instructions?	☐ Yes	☐ No
Cross the street?	☐ Yes	☐ No
Correctly county money?	☐ Yes	☐ No
Remember the steps necessary to board, ride, and alight the bus or train?	☐ Yes	☐ No
Wait for a bus or train at a stop?	☐ Yes	☐ No
Stand for 15 minutes if there is no place to sit?	☐ Yes	☐ No
Walk up and down steps is there is no handrail?	☐ Yes	☐ No
Transfer from one bus or train to another?	☐ Yes	☐ No
Stand on a moving bus or train if there is a handrail?	☐ Yes	☐ No
Have you had a recent fall which required medical attention?	☐ Yes	☐ No

If yes, what is your fall frequency per week? _____

If yes, did the fall occur while using a mobility device or aid? ☐ Yes ☐ No

The following list includes common barriers that prevent people from using the bus or rail system. Do any of these barriers apply to you?

- ☐ Sensitivity to cold or heat
- ☐ Light Sensitivity
- ☐ Lack of curb cuts
- ☐ Hills or slopes
- ☐ Air pollution
- ☐ Unable to transfer buses/trains
- ☐ Unable to walk/wheel ¼ mile (3 blocks)
- ☐ Unable to walk/wheel ¾ mile (9 blocks)
- ☐ Rain
- ☐ Night blindness
- ☐ Lack of sidewalks
- ☐ Uneven travel path
- ☐ Bus stop not accessible
- ☐ Good/bad days
- ☐ Unable to walk/wheel ½ mile (6 blocks)
- ☐ None

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MOBILITY DEVICE

Do you currently use a mobility device when going places? ☐ Yes ☐ No

If yes, check with mobility device(s) you use:

☐ Power/electric wheelchair
☐ Manual wheelchair
☐ Powered scooter
☐ Walker
☐ Service animal
☐ Prosthesis
☐ Leg braces
☐ Other (please describe): _____

☐ Crutches
☐ Portable oxygen in cart
☐ Portable oxygen in bag
☐ Picture/Alphabet/Communication Board
☐ Cane
☐ White cane
☐ None

If you use a wheelchair or scooter, what is the width and length (in inches)?

Width _____ Length _____

If you use a wheelchair or scooter, what is the total weight of your mobility device when you are using it (in pounds)?

Total Weight _____

How long have you been using your mobility device?

Years _____ Months _____

Note: All NCTD vehicles are able to accommodate, at a minimum, all occupied wheelchairs weighing up to 600 pounds and measuring 30 inches in width and 48 inches in length. If you and your wheelchair exceed those specifications, NCTD will make every effort to accommodate you if the combined weight (wheelchair and occupant) does not exceed the lift/ramp specifications and lift/ramp capacity of the vehicle, and when doing so is consistent with legitimate safety requirements as provided by the Department of Transportation ADA regulations.

APPLICANT CERTIFICATION

I understand the purpose of this application is to determine if there are times when I cannot use North County Transit – San Diego Railroad fixed-route bus and rail service and may therefore require the **LIFT** service for my public transportation needs. **I certify** that, to the best of my knowledge, the information in this application is **true** and **correct**. I understand that providing false information may result in denial of service as well as penalty under the law. I agree to undergo an in-person assessment of my mobility abilities and limitations for the purpose of making a determination regarding my eligibility for paratransit service as required. I agree to notify NCTD if my condition changes, if I am using a new mobility device, or if I no longer need to use ADA Paratransit service.

I understand NCTD and/or ADARIDE have the right to review my ADA paratransit eligibility at any time, and where circumstances may warrant, I may become ineligible to receive ADA paratransit services.

Signature _____ Date _____

The following person assisted me in filling out this application:

Print Name

Agency (if applicable) _____

Relationship _____

Number and Street _____ Apt # _____

City _____ State _____ Zip Code _____

Home Phone

Cell Phone _____

Email Address _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

By signing this application, I understand I am giving consent for NCTD and ADARIDE to use and disclose my protected health information to transfer information to transportation providers and mobility services. I hereby give my permission to NCTD and ADARIDE to contact my healthcare provider to verify my disability and treatment plan for purposes of determining paratransit eligibility.

Signature _____ Date _____