615 Johnson Street
Saginaw, Michigan 48607

Client ID #_____

Date Entered_____

Processed by_____

Application for STARS Lift Service

Instructions: On pages 1 – 5 of this application, STARS Lift is asking for information about you and your ability to use STARS bus service. Please take the time to answer ALL questions carefully and completely. We cannot determine your eligibility for STARS Lift service without this information. A friend, guardian, caregiver, agency service representative or family member may help you complete your portion of the application, pages 1- 5. Accurate information is required about you, your medical impairment, and your functional capacity. Pages 6 - 8 must be completed and certified by a physician/certified health professional who is familiar with your impairment or condition.

If you have questions, please call STARS Lift Customer Service at 989-753-9526.

Have you ever applied for STARS Lift? ☐ No ☐ Yes

Please print all information below

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Alternate Phone: _____

Birth Date: _____

INDIVIDUAL AND MOBILITY INFORMATION

1. **Please Describe your physical, sensory, and/or mental disabilities**

2. ***My condition is:***

☐*Permanent* ☐*Temporary* *I expect it to last* _____ *Years and/or* _____ *Months*

The Americans with Disabilities Act sets criteria that must be met in order to be determined eligible for certain transportation services. Eligibility is based not only on the existence of the disability, but on how it affects the applicant's mobility. The following questions are "Accessing" involves getting to and from a bus stop, waiting at the stop, getting on and off the bus, and recognizing the environment.

Please answer the questions based on your current level of mobility, regardless of how it may change in the future.

3. **Explain in detail how your disability prevents you from using STARS fixed route service? Please be very detailed in describing your condition including your medical diagnosis.**

4. **Are you legally blind?** **Yes:**☐ **No:**☐
5. **Have you been diagnosed for psychiatric disability?** **Yes:**☐ **No:**☐
6. **Does this cause you emotional or psychological disorientation?** **Yes:**☐ **No:**☐

7. **Which of the following mobility aids do you use? (Please check all that apply):**

_____ *None* _____ *Manual Wheelchair* _____ *Portable Oxygen*

_____ *Cane* _____ *Powered Wheelchair* _____ *Prosthesis*

_____ *Walker* _____ *Service Animal* _____ *Other:* _____

8. **Do you need a Personal Care Assistant?** **Yes:**☐ **No:**☐

9. **Do you have a Service Animal?** **Yes:**☐ **No:**☐

10. **How far can you travel using a mobility aid or on your own?**

☐ *I cannot travel outside of my residence by myself*

☐ *I can get to the curb in front of my residence by myself*

☐ *I can travel up to ½ block alone*

☐ *I can travel up to 3 blocks alone*

11. **Are you able to get to the nearest bus stop on your own?**

☐ *Yes* ☐ *No or Sometimes – Please Explain* _____

_____

_____

12. **Are you able to board and disembark from a fixed route bus using a wheelchair/passenger lift without assistance (except from the bus driver)?**

☐ *Yes* ☐ *No or Sometimes – Please Explain* _____

_____

_____

13. **Are you able to handle/grasp coins (fare), tickets, railings, handles?**

☐ Yes ☐ No or Sometimes – Please Explain _____

_____

_____

14. **Are you able to keep your balance while seated on a moving fixed route bus in normal operation?**

☐ *Yes* ☐ *No or Sometimes – Please Explain* _____

_____

_____

15. **Are you able to read, hear and/or understand written or verbal instructions?**

☐ *Yes* ☐ *No or Sometimes – Please Explain* _____

_____

_____

16. **Are you able to signal the bus driver that you want to disembark at a certain bus stop?**

☐ *Yes* ☐ *No or Sometimes – Please Explain* _____

_____

_____

17. **Are you able to find your way between familiar locations?**

☐ *Yes* ☐ *No or Sometimes – Please Explain* _____

_____

_____

18. **Are you able to wait outside at a bus stop without assistance for up to 20 minutes?**

☐ *Yes* ☐ *No or Sometimes – Please Explain* _____

_____

_____

AGREEMENT AND AUTHORIZATION:

I state that the information I have provided is true and accurate.

I authorize the release of diagnostic and functional information as requested on pages 5 and 6 to STARS for the sole purpose of making a determination regarding my eligibility for paratransit service (STARS Lift) and understand that personal and medical information will be kept confidential.

I understand that intentionally providing false or misleading information or refusal to undergo an in-person interview assessment is grounds for denial of STARS Lift services.

If approved, I agree to follow the rules and guidelines established by STARS Lift and to promptly inform STARS Lift of any changes in my residence, phone number and, if applicable, my representative's name and phone number; and any significant change in my condition that would affect my level of mobility.

I understand that failure to follow proper procedures or cooperate with STARS Lift staff, demonstrating illegal or disruptive behavior or, if my condition at any time poses a direct threat to the health or safety of others, such situations may result in either suspension and/or termination of service.

We will notify you in writing within 10 business days excluding Saturdays, Sundays, and holidays whether or not your application has been approved. Applicants are to be granted presumptive eligibility if ADA determination of eligibility has not been made within 10 business days of the submission of a completed application. Service must be provided, and the applicant presumed to be eligible, until and unless the determination is complete and the person is found to be ineligible.

If your application is *denied*, you may appeal in writing or in person within 60 days to the Transit Advisory Committee, c/o STARS, 615 Johnson Street, Saginaw, MI 48607.

Applicant's Name _____ Date: _____
(Please Print)

Applicant's Signature _____

If person other than applicant completing form:

Print Name _____ Relationship to Applicant _____

Address _____ Phone _____

Signature _____ Date _____

To be completed by licensed health care professional

We need your assistance in determining eligibility for services provided by STARS Lift to persons with disabilities who are unable to use local bus transportation. We are seeking specific information as to what prevents the person from using the STARS fixed bus routes that provide transportation throughout the area. STARs buses are equipped with ramps, lifts, and kneeling features to assist boarding as well as automatic announcements of major stops to help riders know where they are along the route. The Americans with Disabilities Act of 1990, 49 CFR 37.121, Subpart F states– "..each public entity operating a fixed route system shall provide paratransit or other special service to individuals with disabilities that is comparable to the level of service provided to individuals without disabilities who use the fixed route system." "By complementary, DOT means service for individuals with disabilities who cannot use the fixed route bus system." The information requested of you in the following sections will be used to help determine the applicant's STARS Lift eligibility. It is important that all questions be answered completely and accurately to the best of your knowledge and in accordance with your records. If the information is incomplete or unclear, we may need to contact you for clarification. Thank you for your cooperation.

1. Have you previously seen this patient? ☐ Yes ☐ No

2. Please rate (Excellent / Good / Fair / Poor / None / Don't Know) the applicant in terms of:

	Excellent	Good	Fair	Poor	None	Don't Know
Upper body Strength						
Lower Body Strength						
Coordination						
Balance						
Self-Awareness						
Independent Judgement						
Sense of Direction						
Ability to Understand and Follow instructions						
Verbal Communication						
Written Communication						
Stamina and Endurance						

3. In your opinion, can the applicant travel independently from his/her house to the sidewalk?

☐ Yes ☐ No ☐ Sometimes

If "no" or "sometimes," please explain._____

4. Can the applicant walk up and down two steps? ☐ Yes ☐ No ☐ Sometimes

5. Assuming the use of a mobility aid, if applicable, and with no major barriers in his/her path, how far can the applicant independently travel without assistance?

☐ Less than 1/4 mile ☐ 1/4 mile ☐ 1/2 mile ☐ 3/4 mile ☐ more than 3/4 mile

6. Does the applicant's disability require him/her to travel with another person who provides personal assistance? ☐ Yes ☐ No ☐ Sometimes

7. Please provide medical diagnoses in layman's terms to describe the applicant's primary impairments or disabling conditions. _____

_____

_____

8. We are seeking specific information as to what prevents your patient from accessing the local bus. _____

_____

_____

9. Is the condition ☐ Permanent or ☐ Temporary (months) _____

10. If visually impaired, what is the applicant's best corrected acuity?

(Snellen)? (R)_____(L) _____

Field Restriction: (R)_____ (L) _____ Date of Testing:_____

11. If cognitively impaired, what is the applicant's cognitive age, and IQ level?

_____

12. Is the applicant a wheelchair user? ☐ Yes ☐ No If yes, how often_____

13. Does the applicant use other mobility aids? ☐ Yes ☐ No If yes, please describible.

_____

_____

PHYSICIAN OR HEALTH CARE PROFESSIONAL'S CERTIFICATION : I certify that the information I have provided herein is a fair representation of this applicant's medical impairment or condition and is accurate to the best of my knowledge. I understand that the information provided herein will be used for the sole purpose of determining the applicant's eligibility for paratransit services. I also agree that STARSLift may contact me for clarification of any information I have provided and that I will reply in good faith.

Physician's/Health Professional's Full Name_____

Institution/Facility/Agency Name_____

Street Address_____ Suite # _____

City _____State_____ Zip Code_____

Medical/Social Worker's License Number _____

Telephone #_____Fax #_____

Physician's/
Health Professional's Signature _____Date_____