

IDEP ELIGIBILITY ASSESSMENT CENTER APPLICATION

Please complete this section ONLY when establishing IDEP eligibility at an IDEP Eligibility Assessment Center and bring it to your scheduled appointment.			
Please indicate your application type by placing \checkmark			
□ New IDEP Assessment	Recertification IDEP Client ID Number		

ELIGIBILITY CRITERIA: You are eligible for IDEP if you have a disability that prevents you from using the public buses or subways. We will review your application, any medical documentation you provide, and ask you to undergo an individualized assessment. During the assessment, we will ask you to demonstrate whether you can: go up or down subway stairs; travel to a subway station or bus stop; get on, ride, and exit a subway or bus; and ride or navigate the bus or subway system independently. Evaluating your ability to do these things will help us determine if you are eligible for IDEP. We will also evaluate your gait, balance, endurance, strength, range of motion, and, if applicable, assess whether you have any cognitive or psychological conditions that may prevent you from using the bus or subway.

INSTRUCTIONS: Please complete this application and bring it with you to the scheduled evaluation at the offices of the professional certifier. **To schedule your IDEP assessment call 1-844-233-3377**

Please give the completed application and any supporting documents to the professional certifier. It may take up to 3 weeks after your visit to the assessment center to process your application, after which you will receive a notification on your eligibility status.

Your photograph will be taken at the evaluation center on the day of your scheduled in-person assessment.

All the information you provide will be used solely for determining your eligibility for IDEP. This information will be kept strictly confidential.

Once you have established IDEP eligibility, you will not require another assessment for five (5) years from the date it was approved unless otherwise indicated.

Do you need information in an alternate format or language other than English? Check One: \Box Large Print \Box Audio Tape \Box Braille \Box **Preferred Language:**

IMPORTANT: Your evaluation will not take place if you arrive at the evaluation center with an incomplete application. You will have to reschedule the evaluation.



AGREEMENT TO ELIGIBILITY TERMS AND CONDITIONS (All applicants must sign this agreement)

I understand that as a part of the application process, I, or the person on whose behalf I am applying as a caregiver or representative, must attend an in-person evaluation at the offices of a professional certifier selected by TBTA. I understand that the assessment center reserves the right to request additional proof of my disability or my inability to use public buses and subways. I understand that my application will not be accepted at the assessment center if it is not complete. I affirm that all the information that I provide on this application is true to the best of my knowledge.

I understand that my application is subject to review and verification and that misrepresentation of any material information will lead to termination of my eligibility. I also understand that my failure to cooperate with a request for additional information to verify statements made on my application may be grounds for suspension or termination of my eligibility for IDEP. I further understand that my failure to adhere to the policies and procedures for using IDEP may also be grounds for suspension or termination of my eligibility for IDEP.

Applicant's Signature

Date

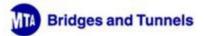
If someone other than the applicant has completed this application, please provide the following information:

Name

Relationship to Applicant

Telephone Number

Date



REQUIRED IDENTIFICATION INFORMATION (Please print clearly)

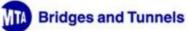
	First Name			M.I.
Street Address			Apt. No	
City/Borough		State	Zip Code	
Cross Streets		and		
Home Telephone Number		Work Teleph	one Number	_=
E-mail Address Cell Pho		Cell Phone N	umber	
	Gende	er		
If your mailing address is d (Otherwise leave blank)	ifferent from your	home address	, please com	plete the follow
If your mailing address is d	ifferent from your	home address	, please com Apt. No.	plete the follow
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If your mailing address is d (Otherwise leave blank) P.O. Box or Street Address		State	Apt. No.	Zip Code
If your mailing address is d (Otherwise leave blank) P.O. Box or Street Address City/Borough		State	Apt. No.	Zip Code
If your mailing address is d (Otherwise leave blank) P.O. Box or Street Address City/Borough Person to Contact in Case o Last Name	of Emergency: (Thi	State	Apt. No.	Zip Code



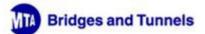
APPLICATION FORM

1.	How do you currently travel? (□ Public Transit Bus□ Subv□ Taxi/Car Service□ Privation	vay	□ Access-A-Ride	
2.	Do you have a MetroCard? (Ch Yes, I use my MetroCard whe			ubway 🗆 No, I don't.
	Is your disability: □Permanent □Temporary: _2 m	onths3 m	onths6 months0	Other: I don't know
4.	Indicate which support device(s)Artificial Limb/ProsthesisOxyBraces/CrutchesRespLift RequiredSupOther (Specify)	rgen Tank pirator port Cane	White Guide CaneWalkerWheelchair*	 Double Wheelchair* Oversized Wheelchair*
5.	Do you have a service animal?	🗖 No	□ Yes, please indic	ate the tasks(s) performed.
	□ Guides me □ Alerts m □ Other (Specify):			Carries items for me.
6.	a. How far from your home is t □ Less than 1 block □ 1 to 2		E	-
	Identify location of the pu	blic transi	t bus stop:	
	b. How long does it take you to Less than 5 minutes 5-		-	-
7.	How often do you travel on pub Daily Deekly Month			Not at All
	If you have used a public transit h	ous in the pa	st, when did you stop	?(Mo./Yr.)
	Why did you stop traveling by	public tran	sit bus?	
8.	a. How far from your home is t	he nearest s	ubway station?	
	\Box ess than 1 block \Box 1 to 2 block	locks 🛛 3 t	o 4 blocks 🛛 5 or r	nore blocks.
	Identify location of the subwa	ay station:-		

b. How long does it take you to walk to the nearest subway station? □ Less than 5 minutes □ 5-10 minutes □ More than 10 minutes □ Not sure



	do you travel us UWeekly	ing the subway? □ Monthly	• Occasionally	□ Not at All
If you have	e used the subway	y in the past, when	did you stop?	(Mo./Yr.)
Why did y	you stop travelin	ng by subway?		
10. On your ow answer in ci		port device, how t	far can you travel o	n a level street? <i>(Please</i>
Less that	an 1 block 🛛 1	to 2 blocks 🛛 3 t	to 4 blocks \Box 5 or	more blocks.
v	1		Care Attendant (PC u travel. 🛛 Yes	,
b. If Yes,	what specificall	y does the PCA d	lo for you when yo	u travel?
check off th □ Not appli	e reasons below cable	v. (Check all that		ansit bus or subway,
check off th □ Not appli □ I feel uns	te reasons belov cable afe traveling by	v. (<i>Check all that</i> public transit bus		ansit bus or subway,
check off th □ Not appli □ I feel uns □ I do not li	te reasons belov cable afe traveling by	v. <i>(Check all that</i> public transit bus public transit bus		ansit bus or subway,
 check off th □ Not appli □ I feel uns □ I do not li □ Distance □ I do not li 	te reasons below cable afe traveling by ike traveling by to public transit ike traveling by	v. (Check all that public transit bus public transit bus bus is too long subway		ansit bus or subway,
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13. From the following list, please check off all disabilities or conditions that prevent you from boarding, riding or disembarking from public transit buses or subways.

Cardiovascular/Pulmonary	Neuromuscular
Angina	ALS/Lou Gehrig's Disease
Arteriosclerosis/Atherosclerosis	_ Cerebral Palsy
Asthma	Charcot-Marie Tooth Syndrome
Bypass Surgery: Date:	Equilibrium
Chronic Obstructive Pulmonary Disease	Fibromyalgia
Congestive Heart Failure	Hemiplegia/Hemiparesis
Cystic Fibrosis	
Emphysema	Muscular Dystrophy
Heart Attack: Date:	Neuropathy
HTN/Hypertension	Paraplegia
Peripheral Vascular Disease	Parkinson's Disease
Phlebitis	Polio
Thrombosis	Quadriplegia
Other:	Sciatica
	Spina Bifida
General Medical	Stroke/Cerebral Trauma: Date:
AIDS	TIA's (Transient Ischemic Attack)
Atrophy	Other:
Chemotherapy Treatment Dates:	
	Orthopedic
Diabetes	Amputation: specify extremity (ies)
Edema	
Epilepsy	Broken/Fracture: Date:
HIV	Degenerative Joint Disease
Lupus	Gout
Rheumatoid Arthritis	_ Hip Replacement
Kidney Dialysis	Knee Replacement
Radiation Treatment Dates:	
	_ Osteoporosis
Other:	Scoliosis
	Spondylitis
	Other:
Vision [Specify eye (s)] One Eye Both Eyes	Cognitive/Psychological
Cataracts	Alzheimer's Disease
Cortical Blindness	ADD/Attention Deficit Disorder
Glaucoma (all types)	Autism
Macular Degeneration	Dementia

.____

Head Trauma

Panic Disorder

Schizophrenia

Intellectual/Developmental

Other:

Retinal Detachment

Totally Blind Other: _____

Legally Blind



14. Please explain why you	believe you need IDEP service
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15. From your residence, what are the addresses of your three (3) most frequent destinations?

ucsunations.					
Destination Address	Cross Streets	Borough	How often Do You Travel To This Location (Specify)?		
			Daily	Wkly	Mthly
1.					
2.					
3.					

PLEASE REMEMBER THAT YOU MUST:

- Complete and sign the Agreement section.
- Complete the application (please be sure to answer every question) and bring it with you when you go to the assessment center.