



530 North Rose Street  
Kalamazoo, Michigan 49007  
Telephone: 269-337-8446  
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www.kmetro.com

**KALAMAZOO METRO TRANSIT  
METRO COUNTY CONNECT CERTIFICATION APPLICATION**

**PROFESSIONAL VERIFICATION OF FUNCTIONAL LIMITATION  
AFFECTING MOBILITY USED TO DETERMINE  
ADA COMPARABLE PARATRANSIT ELIGIBILITY**

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Your patient/client \_\_\_\_\_ has submitted an application for ADA Comparable Paratransit Service to Kalamazoo Metro Transit and has indicated that you can provide information regarding his/her disability. Federal law requires that Kalamazoo Metro Transit provide paratransit services accessible to persons who cannot use our fixed-route accessible bus service.

Please take a moment to fill out the following questions regarding your patient's mobility capabilities, and return this questionnaire by \_\_\_\_\_ to Kalamazoo Metro Transit, Attn: Metro County Connect Coordinator, 530 N. Rose Street, Kalamazoo, MI 49007-3638, or fax via (269) 337-8211. An authorization from your patient/client is included with this request.

The information you provide will be used with other information to determine your patient's eligibility for our paratransit service. Please note that we are not asking you to make an eligibility decision, but only to provide us with information about this individual's disabilities.

**Please complete each question with as much detail as possible; this will assist in determining the applicant's eligibility. All information will be kept confidential.**

Thank you for your prompt attention to this request. If you have any questions regarding this part of the ADA Paratransit application process, please do not hesitate to contact me at (269) 337-8477 or [congdonr@kmetro.com](mailto:congdonr@kmetro.com)

Sincerely,

Central County Transportation Authority

Richard G. Congdon  
Metro County Connect Coordinator

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Name of Patient/Client: \_\_\_\_\_

Name of Professional: \_\_\_\_\_

Health Organization: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Please specify the applicant's disability (formal diagnosis):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How does the applicant's physical or cognitive condition(s) cause functional limitations that adversely affect his/her mobility and prevents the applicant from using fixed-route bus service?  
**Please Be Specific**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does this person require a Personal Care Attendant in order to use public transportation?

\_\_\_\_\_ Yes      \_\_\_\_\_ No

If yes, please describe why: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Metro County Connect Access is a curb-to-curb service, but also offers door-to-door service to passengers who require additional assistance due to their disability. Does your client/patient require door-to-door service in order to use public transportation?

\_\_\_\_\_ Yes                  \_\_\_\_\_ No

If yes, please describe why: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

In order that your client's/patient's condition can be properly evaluated, please indicate his/her ability with regard to the following:

How many city blocks can your client/patient walk without assistance? \_\_\_\_\_ blocks

If your client/patient uses a mobility device, how many city blocks can he/she travel using this device? \_\_\_\_\_ blocks

How many 12-inch high steps can your client/patient climb without assistance? \_\_\_\_\_ steps

How long can your client/patient stand and wait without support or sit in an outdoor environment? \_\_\_\_\_ minutes

Is the applicant able to:

Use the fixed-route bus independently? \_\_\_\_\_ Yes                  \_\_\_\_\_ No

Read information signs? \_\_\_\_\_ Yes                  \_\_\_\_\_ No

Know where to get on/off the fixed-route bus? \_\_\_\_\_ Yes                  \_\_\_\_\_ No

Ask for, understand and follow spoken directions? \_\_\_\_\_ Yes                  \_\_\_\_\_ No

Recognize a destination or landmark? \_\_\_\_\_ Yes                  \_\_\_\_\_ No

Communicate addresses, destinations or phone numbers? \_\_\_\_\_ Yes                  \_\_\_\_\_ No

If you answered no to any questions above, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate any other limitations that may affect your client's/patient's mobility:

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Is your client's/patient's health condition or transportation disability temporary?

- Yes, I expect it to last for another \_\_\_\_\_ months
- No, it is a permanent condition
- I do not know

Has your client/patient had this health condition or transportation disability for more than one year?

- Yes
- No
- I do not know

Please indicate below any additional information you can provide that will assist Metro County Connect in determining your client's/patient's eligibility for paratransit service.

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\_\_\_\_\_  
**Signature of Professional**

\_\_\_\_\_  
**Date**

**Thank you for taking the time to complete this verification for your client/patient.**

I authorize the release of all personal and medical information for my application for Metro County Connect paratransit service. All information will be kept confidential.

\_\_\_\_\_  
**Applicant Signature**

\_\_\_\_\_  
**Date**