



AMERICANS WITH DISABILITIES ACT CERTIFICATION APPLICATION

Name of Applicant: _____

Street Address: _____

City/State/ZIP: _____

Home Telephone: _____

Work Telephone: _____

Date of Birth: _____

FOR OFFICE USE ONLY

Alternate Format N T B L P E Certification C U T

Date Rec'd. _____ Mob Device _____

Determination Due _____ Expiration _____

Med. Ref. Req. _____ Letter Sent _____

Med. Ref. Rec'd. _____ Jurisdiction _____

ID # _____

Disability Type _____

Disability Description _____

PCA? _____ Yes _____ No Door-to-Door _____ Yes _____ No

INTRODUCTION & INSTRUCTIONS

Metro is **your** public transit system. Our mission is to provide the community with public transportation services that are dependable, convenient, safe, cost effective, and **accessible for all**.

Metro provides three transportation services: accessible, fixed-route bus service; county-wide demand/response Metro Connect service; and an Americans with Disabilities Act (ADA) paratransit service called Metro Connect Access. For individuals who are unable to use the accessible fixed-route bus service some or all of the time, Metro Connect Access offers origin-to-destination transportation service. Metro Connect Access provides paratransit service that is comparable to the transit service individuals receive when they use our fixed-route bus system. The Americans with Disabilities Act ensures this privilege.

In order to determine whether you are eligible for Metro Connect Access service, we need to know if there is any part of the accessible bus system you cannot use due to your disability. Eligibility is not based on the disability itself, but on how it prevents you from using the accessible bus routes. It is possible for you to be eligible for some trips, but not others. If this is the case, you will be paratransit eligible *with conditions*, the conditions being the circumstances preventing your use of the accessible bus system.

ADA paratransit eligible individuals fall into one of the following definitions:

- Any individual with a disability who is unable, as the result of a physical or mental impairment (including a vision impairment), to board, ride, or disembark from a fixed-route vehicle on the Metro System.
- Any individual with a disability who needs the assistance of a wheelchair lift or other boarding assistance device and is able, with such assistance, to board, ride, or disembark from any vehicle, and one is not available on the route.
- Any individual with a disability who has a specific impairment-related condition which prevents the individual from traveling to a boarding location or from a disembarking location served by the fixed-route system.

This application will help Metro Connect determine whether you qualify for paratransit service according to the criteria noted above. Return your completed application to: **Metro Connect, 530 N. Rose St., Kalamazoo, MI 49007**; you will need to apply postage. Completed applications can also be **faxed** to Metro at **269-337-8211**.

The enclosed **Physician or Agency Professional Verification Form** asks you to designate the health care or rehabilitation professional that is most familiar with your ability to travel. The person you designate could be a physician, a physical or occupational therapist, a case manager or another health care professional who is very familiar with your mobility and is qualified to make a determination. Metro may contact that person to verify your mobility status.

When Metro Connect receives your **completed** application, it will be reviewed for eligibility. You will be notified within 21 days if your application is approved, approved with conditions, or denied. If your application is approved with conditions or not approved, you have the right to appeal and have an opportunity to provide additional information for reconsideration. You will receive the appeal process with your letter.

If the review exceeds 21 days the applicant is given presumptive eligibility and can use **Access** service until a determination is made. You will receive written notice of your eligibility if the 21 day review period is not met.

If approved, your certification will be active for three years. Two months prior to the end of that 3-year period you will be notified and provided with a Certification Renewal form.

If you have any questions about this form or need it provided in a different format, please call Metro Connect at (269) 337-8477.

The information obtained in this certification process will only be used by the Metro System for the provision of ADA complementary paratransit service. Information will only be shared with other transit providers to facilitate your travel in their operating areas, should you request it. This information will not be provided to any other person or agency and will be kept strictly confidential.

Please be sure to complete all parts of this application; applications cannot be processed unless all questions are completed. Be sure to complete the front cover with the applicant's personal information.

APPLICANT'S QUESTIONNAIRE

Do you need this application and future written information provided in a different format?

_____ Yes _____ No

If Yes, specify below or call (269) 337-8477.

_____ Large Print _____ Braille
_____ Audiotape _____ Other _____

Email _____

If No, please continue.

Emergency Contact Person:

Name _____

Phone # _____

Person Completing Form (if other than Applicant):

Name _____

Agency _____

Phone # _____

Email _____

Signature _____

CERTIFICATION OF APPLICANT

I certify that the information I provide in this application is true and correct. I understand that falsification may result in denial of service and/or penalty under law. I understand all information will be kept confidential and only the information required to provide the service I request will be disclosed to those who perform those services.

Applicant's Signature

Date

EXTENT OF DISABILITY

Please indicate your ability to perform the following actions by checking the phrase or completing the blank.

Can you read informational signs?

- _____ Yes, I can
- _____ With moderate difficulty
- _____ With extreme difficulty
- _____ No, I cannot

Can you stand in a moving vehicle?

- _____ Yes, I can
- _____ With moderate difficulty
- _____ With extreme difficulty
- _____ No, I cannot

Once on a fixed-route bus, can you get to a seat or a wheelchair position by yourself?

- _____ Yes
- _____ No
- _____ Sometimes

Can you hear announcements or spoken directions?

- ☐ Yes, I can
- ☐ With moderate difficulty
- ☐ With extreme difficulty
- ☐ No, I cannot

How many city blocks can you travel without assistance, using a mobility aid or on your own?

blocks

How many 12-inch high steps can you climb without assistance?

steps

How far (in city blocks) is the closest bus stop to your residence?

blocks

How long can you stand and wait without support or sit in an outdoor environment?

minutes

Please check below each question the phrase that best answers the question.

Is your health condition or transportation disability **temporary**?

- ☐ Yes, I expect it to last for
 (indicate time)
- ☐ No, it is a permanent condition
- ☐ I do not know

Have you had this health condition or transportation disability for more than one year?

_____ Yes
_____ No
_____ I do not know

Does your health condition or transportation disability change from day to day in a way that makes it very difficult to use fixed-route buses?

_____ Yes, my condition is good some days and bad other days.
_____ No, my condition does not change much from day to day.
_____ I do not know.

If you have a health condition or disability that changes from day to day, please check below each statement the phrase that best describes your ability to travel, using a mobility aid (see list on page 9) or on your own.

On a day when my health condition is *good*: (pick only 1)

_____ I cannot travel outside my house.
_____ I can get to the curb in front of my house.
_____ I can travel up to _____ blocks.
_____ I do not want to travel outside.

On a day when my health condition is *bad*: (pick only 1)

_____ I cannot travel outside my house.
_____ I can get to the curb in front of my house.
_____ I can travel up to _____ blocks.
_____ I do not want to travel outside.

Does the weather ever keep you from using fixed-route buses?

Yes. Tell us how the weather keeps you from using fixed-route buses:

_____ No
I do not know.

If the weather affects your ability to use fixed-route buses, please tell us how far you can travel, using a mobility aid (see list on page 9) or on your own.

When the weather is *good*: (pick only 1)

_____ I cannot travel outside my house.
 _____ I can get to the curb in front of my house.
 _____ I can travel up to _____ blocks.
 _____ I do not want to travel outside.

When the weather is *bad*: (pick only 1)

_____ I cannot travel outside my house.
 _____ I can get to the curb in front of my house.
 _____ I can travel up to _____ blocks.
 _____ I do not want to travel outside.

Please check below all that apply with regard to your need for mobility aids:

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

- ☐ Cane
- ☐ White cane
- ☐ Walker
- ☐ Crutches
- ☐ Prosthesis
- ☐ Manual wheelchair
- ☐ Powered wheelchair
- ☐ Powered scooter/cart
- ☐ Boarding chair
- ☐ Service animal
- ☐ Communication board
- ☐ Portable oxygen
- ☐ None of these
- ☐ Other (indicate) _____

If you use a manual or powered wheelchair or scooter, is it more than 30 inches wide, more than 48 inches long, or does it, when in use, weigh more than 600 pounds?

_____ Yes _____ No

If you require a Personal Care Attendant to accompany you when you travel by public transit, check all that apply below:

- ☐ I always need a Personal Care Attendant.
- ☐ I sometimes need a Personal Care Attendant.
- ☐ I need a Personal Care Attendant to:
 - ☐ Get to the bus stop
 - ☐ Get on or off the bus
 - ☐ Help me while I ride the bus
 - ☐ Help me get to where I am going once I am off the bus
 - ☐ When I use paratransit services
 - ☐ Other (indicate) _____

FIXED-ROUTE SERVICE

Please answer the following questions with regard to fixed-route Metro service:

Which of the following limit your ability to use fixed-route buses (check all that apply):

- ☐ Physical disability
- ☐ Visual impairment/blindness
- ☐ Developmental disability
- ☐ Mental illness
- ☐ Other (indicate) _____

Can you follow written or oral instructions to use the fixed-route buses? (check all that apply):

- ☐ Yes, always
- ☐ Yes, sometimes
- ☐ No
- ☐ I do not know, because I have never tried it.
- ☐ I get too confused and might get lost.
- ☐ I do not want to ride fixed-route buses.
- ☐ I probably could with training.
- ☐ Other (indicate) _____

Do you know where to get on/off the bus? (check all that apply):

- ☐ Yes, always
- ☐ Yes, sometimes
- ☐ No
- ☐ I get confused or cannot remember where I am going.
- ☐ I do not know where my bus stop is located.
- ☐ I can if the driver calls out the stops.
- ☐ I probably could with training.
- ☐ Other (indicate) _____

Do you now use fixed-route Metro buses?

_____ Yes _____ No (answer next question):

If No, what would help you ride the fixed-route buses? (check all that apply):

_____ Knowing more about fixed-route buses.
_____ Learning to travel in the community.
_____ A lift or ramp (accessible bus).
_____ Communications aid
_____ Other (indicate) _____

Can you get on and off a fixed-route bus when it has a passenger lift or ramp? (Either standing or with a mobility aid.)

_____ Yes, always
_____ Yes, sometimes
_____ No
_____ I do not need to use the lift/ramp.
_____ I do not know because I have never tried it.

If No, what is the reason you cannot get on and off a fixed-route bus? (check all that apply):

_____ My mobility aid will not fit on the lift.
_____ I cannot steady myself when the lift is moving.
_____ I do not want to use the lift.
_____ I do not feel secure on the lift.
_____ I probably could with training.
_____ Other (indicate) _____

PHYSICIAN OR AGENCY PROFESSIONAL AUTHORIZATION

Please check one response below:

_____ My signed Physician or Agency Professional Verification form was provided to (indicate name) _____ who can be reached at telephone # _____.

_____ My signed Physician or Agency Professional Verification form is enclosed. Please forward this form to my designated professional. **Physician or Agency Fax Number:** _____.

Is there any other information not covered in this application that you would like Metro Connect to consider when reviewing your eligibility for paratransit services?

Return completed application form to:

Metro Connect
Attn: Program Manager
530 N. Rose Street
Kalamazoo, MI 49007-3638
Fax #: 269-337-8211

If you have any questions regarding completion of this application form, the process for becoming certified or using Metro Connect Access, please contact our Metro Connect Coordinator at (269) 337-8477.



530 North Rose Street
Kalamazoo, Michigan 49007
Telephone: 269-337-8477
Fax: 269-337-8211
www.kmetro.com

METRO
METRO 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 Metro and has indicated that you can provide information regarding his/her disability. Federal law requires that Metro 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 Metro, Attn: Metro Connect Program Manager, 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 disability.

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

Sincerely,

Central County Transportation Authority

Richard G. Congdon

Richard G. Congdon
Metro Connect Program Manager

METRO
METRO CONNECT CERTIFICATION APPLICATION

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

Name of Patient/Client: _____

Name of Professional: _____

Health Organization: _____

Street Address: _____

City/State/ZIP: _____

Telephone Number: _____

Email: _____

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 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:

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 Connect in determining your client's/patient's eligibility for paratransit service.

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 Connect paratransit service. All information will be kept confidential.

Applicant Signature

Date