

# Metro

## ADA PARATRANSIT RENEWAL APPLICATION

In accordance with the Americans with Disabilities Act of 1990 (ADA), Metro and St. Clair Transit District provide “paratransit” (van/shared-ride) services to individuals with disabilities who are unable to use the fixed route services (i.e. buses - MetroBus or light-rail-MetroLink). Individuals served do not have to reside in the area, but they must be traveling within an area served by MetroBus or MetroLink. The purpose of this application is to provide an opportunity for you to describe barriers in the environment and limitations that you may have which prevent you from using available fixed route services. The information that you provide will help the transit agencies to understand your abilities and travel challenges. **All information contained in this application will be kept confidential and shared only with the professionals involved in evaluating your eligibility.**

**All** applicants, whether new or individuals applying for recertification, must complete a new application and provide **written** professional verification of disability. The ADA certification process will include a personal functional assessment to determine if and under what conditions, you can use fixed route services. The evaluation focuses on your abilities and will be performed at no cost to you. Free transportation to and from the evaluation site will be provided upon request.

All questions must be answered. Incomplete forms will be returned. **If you have any questions or need assistance completing this form, please call (314) 982-1510. To request the form in an alternative format, please contact Amy Parker, ADA Coordinator, at (314) 982-1525 or [adadirector@metrostlouis.org](mailto:adadirector@metrostlouis.org).**

Metro’s ADA Paratransit Eligibility process includes:

1. Receipt of completed application including professional verification of disability.
2. An in person functional assessment of transit-related skills.
3. Metro will schedule your assessment upon your request once Metro has received your completed application and notify you of the eligibility determination no later than 21 days following the date of your scheduled assessment. If Metro is not able to schedule your assessment within 10 days of your request, or your determination is not made by 21 days after your scheduled assessment, you will be granted **Presumptive Eligibility**. Presumptive Eligibility will permit you to use Call-A-Ride or ATS services until a final determination has been made regarding your ADA eligibility for these services. If Metro did not cause the delay, you will not be granted presumptive eligibility. You may call (314) 982-1510 to learn more about presumptive eligibility.

**Please return this completed application including written professional verification of disability. MAIL: Metro, One Metropolitan Square, 211 N. Broadway-Suite 700, St. Louis, MO 63102 FAX: (314) 335-3419**

**Please call Metro Staff at (314) 982-1510 seven days after mailing or two days after faxing to schedule your assessment appointment.**

**Please keep this page for future reference & see both sides for tips to help avoid processing delays as well as information about transportation to the assessment.**

# TO AVOID ANY PROCESSING DELAY

Applicant: Metro is committed to processing your application in a timely manner, but we need your help. Please ensure that all parts of the application and attachments are completed before submittal to Metro. Please tell us about all disabilities that you have. **Please note that written professional verification of disability is required and must be submitted with the application.** This professional verification must be completed by a professional who is familiar with your disability such as a doctor, social worker, counselor, independent living specialist, teacher, orientation & mobility specialist, etc... There is a professional verification form included with the application that may be used for this purpose or a letter may be submitted on professional letterhead.

**Applications that are incomplete or lack adequate professional verification of disability cannot be processed. Thank you in advance for your cooperation in submitting all of the required information.**

## GENERAL INFORMATION

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ Apt#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ TTY:  Yes  No

Home Phone: (\_\_\_\_) \_\_\_\_\_ TTY:  Yes  No

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  Female  Non-Binary

Social Security Number: \_\_\_\_\_ -- \_\_\_\_\_ -- \_\_\_\_\_

Current or previous Call-A-Ride ID card# \_\_\_\_\_ Expires (ed) \_\_\_\_\_

Do you NEED future written information provided to you in an accessible format?

Yes  No  If YES: Please indicate your preferred format:

Email \_\_\_\_\_  Braille

Large Print  Other (Specify) \_\_\_\_\_

Emergency Contact Person:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Day Phone: (\_\_\_\_) \_\_\_\_\_ Eve. Phone: (\_\_\_\_) \_\_\_\_\_

Did anyone assist you with completing this form?  Yes  No

If yes, please provide the following information about that person.

Name \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

## APPLICANT'S CERTIFICATION

Please Complete Section A UNLESS you are a minor or have a legal guardian. If you are a minor or have a legal guardian, your parent or guardian must complete Section B.

A. I understand that the purpose of this application is to determine if there are times that I cannot use fixed route services and am eligible to use the shared ride services of Metro CALL-A-RIDE or ATS. I certify that the information provided in this application is accurate and I understand that I must complete a functional assessment of my abilities.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

B. I understand that the purpose of this application is to determine if there are times that the applicant cannot use fixed route services and is eligible to use the shared ride services of Metro CALL-A-RIDE or ATS. I certify that the information provided in this application is accurate and I understand that the applicant must complete a functional assessment of his or her abilities.

I consent to the Applicant's interview and functional assessment of his or her travel abilities and limitations to determine ADA Paratransit service eligibility. I understand that the Applicant must be present for the interview and functional assessment. I understand that if the applicant travels to the assessment on ATS or Call-A-Ride, he or she will not be supervised by the driver or assessment office staff. He or she may transfer from one Call-A-Ride van to another on his or her trip. If these issues cause concern, he or she may bring an attendant at no charge. I understand that I may be present with the Applicant during the interview and any functional assessment, and state that:

I will be present,

I designate \_\_\_\_\_ to be present on my behalf,  
or

I waive my right to be present and do not designate another person to be present on my behalf.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to applicant: \_\_\_\_\_

## INFORMATION ABOUT YOUR DISABILITY AND MOBILITY EQUIPMENT

1. What type or types of disabilities prevent you from using MetroBus or MetroLink? Please check all that apply.

- |   |  |
|---|--|
| <input type="checkbox"/> Physical disability      | <input type="checkbox"/> Visual impairment/Blindness |
| <input type="checkbox"/> Developmental disability | <input type="checkbox"/> Brain injury                |
| <input type="checkbox"/> Mental illness           | <input type="checkbox"/> Other                       |
- 

2. Please describe your disability (or disabilities) in more detail, including the diagnosis (or diagnoses).

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3. Has your disability changed since your last assessment?

- |   |   |
|---|---|
| <input type="checkbox"/> Yes, for the better. | <input type="checkbox"/> Yes, I have a new disability since my last assessment. |
| <input type="checkbox"/> No.                  |   |
| <input type="checkbox"/> Yes, for the worse.  |   |

4. Which of the following mobility aids do you use when traveling or walking outside your home? Please check all that apply.

- |   |   |
|---|---|
| <input type="checkbox"/> I don't use a mobility aid | <input type="checkbox"/> Scooter              |
| <input type="checkbox"/> Braces                     | <input type="checkbox"/> Prosthesis           |
| <input type="checkbox"/> Cane                       | <input type="checkbox"/> Portable Oxygen Tank |
| <input type="checkbox"/> Long white cane            | <input type="checkbox"/> Walker               |
| <input type="checkbox"/> Manual Wheelchair          | <input type="checkbox"/> Service Animal       |
| <input type="checkbox"/> Power Wheelchair           | <input type="checkbox"/> Communication Device |

5. Is this a different device that used during your last assessment?

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

6. If you use a wheelchair or scooter, is it? (Check all that apply):

- 30 inches wide or less
- 48 inches long or less
- 600 pounds or less when occupied

7. Has your ability to use MetroBus or MetroLink changed since your last assessment?

- Yes, for the better.
- No, it's about the same.
- Yes, for the worse.

8. How have you been traveling for the past six months? (Check all that apply)

- |  |                                     |
|--|-------------------------------------|
| <input type="checkbox"/> MetroBus                  | <input type="checkbox"/> School Bus |
| <input type="checkbox"/> MetroLink                 | <input type="checkbox"/> Walking    |
| <input type="checkbox"/> Call-A-Ride/ATS           | <input type="checkbox"/> Bike       |
| <input type="checkbox"/> Car                       | <input type="checkbox"/> OATS       |
| <input type="checkbox"/> Taxi                      | <input type="checkbox"/> Other:     |
| <input type="checkbox"/> Medical Transport Service |                                     |

9. Do you currently travel by MetroBus or MetroLink by yourself?

- Yes
- Sometimes
- No

9 a. If Yes or Sometimes, how often?

- |   |                                  |
|---|----------------------------------|
| <input type="checkbox"/> Daily                | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Several times weekly | <input type="checkbox"/> Rarely  |
| <input type="checkbox"/> Weekly               |                                  |

10. Have you ever had training on how to use MetroBus or MetroLink?

- Yes
- No

10 a. Did you complete the training?

- Yes, please complete 10 b and 10 c
- No, please complete 10 d

10 b. If Yes, please check all skills you have learned:

- |   |   |
|---|---|
| <input type="checkbox"/> General bus travel                                   | <input type="checkbox"/> Safely crossing the street   |
| <input type="checkbox"/> General rail travel                                  | <input type="checkbox"/> How to transfer from vehicle to another  |
| <input type="checkbox"/> Getting to and from bus stops and MetroLink Stations | <input type="checkbox"/> How to handle bus or rail fare   |
| <input type="checkbox"/> Getting on or off a bus or MetroLink Vehicle         | <input type="checkbox"/> How to get from one specific place to another (for example, home to and from work) |
| <input type="checkbox"/> What to do in emergency situations                   | <input type="checkbox"/> How to read the bus and train schedule   |

10 c. Please list destinations that you can independently reach using MetroBus and MetroLink.

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10 d. If no, please state why you did not complete the training.

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11. What is your strategy to travel to an unfamiliar place on MetroBus or MetroLink?

- I check the Trip Finder website.
- I call Metro at 231-2345 for directions.
- I only travel to unfamiliar places with a friend.
- I ask my travel trainer for assistance.
- I use Call-A-Ride to go to unfamiliar places.

12. Would you be interested in receiving training on MetroBus or MetroLink?

Yes

No

13. Which of these can help you to successfully use MetroBus or MetroLink?

An accessible path

A bus that is not crowded

Curb Cuts

Landmarks that I can detect with my white cane

Traffic signals to help me safely cross the street

A ride to the bus stop or train station

A seat on the vehicle

My mobility device

A seat at the bus stop

A path that is smooth and even

14. Which of these PREVENT you from using the Metro Bus or Metro Link?

Extreme Heat

Strong Wind

Extreme Cold

Bright Sunlight

Heavy Snow and Ice

Darkness

15. Please use this space to tell us anything else you would like us to know about your travel challenges and your ability to use buses and or MetroLink.

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**TO AVOID ANY DELAY WITH PROCESSING YOUR APPLICATION: Please review this form to make sure that you have completed all of the questions to the best of your ability. Be sure to sign the application. Return the application by mail to: METRO, One Metropolitan Square 211 N. Broadway – Suite 700 St. Louis MO 63102, or by fax to (314) 335.3419**



# Professional Verification

Page 1 of 2

Dear Professional:

You are being asked by \_\_\_\_\_ (applicant) DOB: \_\_\_\_\_  
SS# (last 4 digits): \_\_\_\_\_ to provide information regarding his/her ability to use  
our transit system. Federal law requires that Metro (Call-A-Ride / ATS) provide Paratransit  
services to persons who cannot use fixed-route transit services. The information you  
provide about the noted disability or disabilities will allow us to evaluate this request and its  
application to specific trip requests. This does not include persons who find it  
uncomfortable or difficult to get to and from bus stops or rail stations.

To qualify for ADA Paratransit services, a person must be unable to use regular fixed-route  
transit due to a physical or mental disability. Indicate below, the nature of the applicant's  
disability.

**For all applicants**--Please specify the disability/disabilities of the applicant.  
Please include DSM-V or ICD 10 codes, if available.

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

DSM-V and/or ICD-10 Codes: \_\_\_\_\_

**For applicants with seizure disorder—**

Date of onset: \_\_\_/\_\_\_/\_\_\_

Type of seizures: \_\_\_\_\_

Frequency of seizures: \_\_\_\_\_

Date of last seizure (if known): \_\_\_/\_\_\_/\_\_\_

An indication of the effectiveness of the medication(s) in controlling seizures:

\_\_\_\_\_

Presence/Absence of Aura:

\_\_\_\_\_

**For applicants who have had a stroke—**

American Heart Association Stroke Outcome Classification: \_\_\_\_\_

**For applicants with blindness or low vision—**

Best Corrected Vision: \_\_\_/\_\_\_ OS \_\_\_/\_\_\_ OD Visual Field: \_\_\_\_\_ degrees

**Professional Verification Page 2 of 2**  
**For applicants who have a cardiac condition—**

American Heart Association Classification: \_\_\_\_\_

Precautions regarding activity: \_\_\_\_\_

Precautions regarding extreme heat and cold (in terms of activity level as well as tolerance to sitting/waiting): \_\_\_\_\_

**For all applicants--**Please describe how the applicant's disability prevents him or her from using MetroBus or MetroLink.

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

**For all applicants--**Please list any activity or environmental precautions:

\_\_\_\_\_

The disability is \_\_\_\_\_ Permanent or \_\_\_\_\_ Temporary.  
If the disability is temporary, expected duration is \_\_\_\_\_ months.

Your professional area of specialization is, check one:

- |  |  |
|--|--|
| <input type="checkbox"/> Audiologist                       | <input type="checkbox"/> Registered Nurse/Licensed Practical Nurse |
| <input type="checkbox"/> Rehabilitation Specialist         | <input type="checkbox"/> Physical/Occupational/Speech Therapist    |
| <input type="checkbox"/> Physician                         | <input type="checkbox"/> Independent Living Specialist             |
| <input type="checkbox"/> Optometrist                       | <input type="checkbox"/> Psychologist                              |
| <input type="checkbox"/> Physician Assistant               | <input type="checkbox"/> Case Manager                              |
| <input type="checkbox"/> Social Worker                     | <input type="checkbox"/> Other: _____                              |
| <input type="checkbox"/> Orientation & Mobility Specialist |  |

Your Name/Title: \_\_\_\_\_

Agency/Company Name: \_\_\_\_\_

Professional License # (if applicable): \_\_\_\_\_

Office Address: \_\_\_\_\_

Office Phone #: (\_\_\_\_\_) \_\_\_\_\_ -- \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_ -- \_\_\_\_\_

I hereby certify that the above information is true. Metro (1) may verify the validity of the professional providing the certification, (2) make the final determination on an applicant's eligibility for ADA Paratransit Service.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Please return by mail to METRO, One Metropolitan Square 211 N. Broadway – Suite 700  
St. Louis MO 63102 or by fax to (314) 335.3419**