Metro

ADA PARATRANSPORT 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.

Metro’s ADA Paratransit Eligibility process includes:

1. Receipt of completed application including professional verification of disability.
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.

☐ Physical disability       ☐ Visual impairment/Blindness
☐ Developmental disability ☐ Brain injury
☐ Mental illness           ☐ Other

__________________________________

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

_____________________________________________________

________________________________________________________

________________________________________________________

3. Has your disability changed since your last assessment?
   ☐ Yes, for the better.       ☐ Yes, I have a new disability since my last assessment.
   ☐ No.                        ☐ 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.

☐ I don’t use a mobility aid       ☐ Scooter
☐ Braces                          ☐ Prosthesis
☐ Cane                            ☐ Portable Oxygen Tank
☐ Long white cane                  ☐ Walker
☐ Manual Wheelchair               ☐ Service Animal
☐ Power Wheelchair                ☐ Communication Device

5. Is this a different device that used during your last assessment?
   ☐ Yes                        ☐ 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)
   □ MetroBus
   □ MetroLink
   □ Call-A-Ride/ATS
   □ Car
   □ Taxi
   □ Medical Transport Service
   □ School Bus
   □ Walking
   □ Bike
   □ OATS
   □ Other:

9. Do you currently travel by MetroBus or MetroLink by yourself?
   □ Yes
   □ No
   □ Sometimes

9 a. If Yes or Sometimes, how often?
   □ Daily
   □ Several times weekly
   □ Weekly
   □ Monthly
   □ Rarely

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:
   □ General bus travel
   □ General rail travel
   □ Getting to and from bus stops and MetroLink Stations
   □ Getting on or off a bus or MetroLink Vehicle
   □ What to do in emergency situations
   □ Safely crossing the street
   □ How to transfer from vehicle to another
   □ How to handle bus or rail fare
   □ How to get from one specific place to another (for example, home to and from work)
   □ How to read the bus and train schedule

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

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

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  □ A seat at the bus stop
   □ A path that is smooth and even  □ My mobility device

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

____________________________________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________________

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
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:

☒ Audiolist
☒ Rehabilitation Specialist
☒ Physician
☒ Optometrist
☒ Physician Assistant
☒ Social Worker
☒ Orientation & Mobility Specialist
☒ Registered Nurse/Licensed Practical Nurse
☒ Physical/Occupational/Speech Therapist
☒ Independent Living Specialist
☒ Psychologist
☒ Case Manager
☒ Other:________________________________________

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