ADA Paratransit Application Information Sheet

Included in this packet:

1. White Forms: Instruction on completing the enclosed application – please keep for reference during and after filling out the form(s)
2. Yellow Forms: Paratransit Applicant Form/Application
3. Blue Forms: Professional Verification Form

Read the entire packet before completing form(s). To avoid delay in processing, answer all questions to the best of your ability and review the form(s) before submitting. Sign the application. Give the Professional Verification form to your healthcare provider.

Return Application Options

Via U.S. Mail:
Metro Transit
Attn: Mail Stop 1
One Metropolitan Square
211 N. Broadway, Ste. 700
St. Louis, MO 63102

Via FAX:
(314) 335-3419

Website Upload:
MetroStLouis.org/ADAUpload

If you have questions or need assistance completing the ADA Paratransit Application form, please call (314) 982-1510. To request a form in an alternate format, contact Amy Parker, ADA Coordinator; (314) 982-1525 or ADACoordinator@MetroStLouis.org.

Please keep this page for future reference

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ADA Paratransit Application Instructions

In accordance with the Americans with Disabilities Act of 1990 (ADA), Metro Transit 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.

All applicants, whether new or individuals applying for recertification, must complete a new application and provide written professional verification of disability.

Please note that eligibility for Metro Call-A-Ride (CAR) and Alternative Transportation Service (ATS) is a transportation decision and not a medical one. Determinations are based on an individual’s ability to use fixed route services, and not solely based on disability, age or medical diagnosis. Perceived inconvenience, real inconvenience or simply a desire not to use fixed route services are not criteria for eligibility.

All information contained in this application is kept confidential. All questions must be answered. Incomplete forms cannot be processed.

Please keep this page for future reference

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ADA Paratransit Application Instructions

Please call Metro Staff at (314) 982-1510 to schedule your assessment appointment seven (7) days after mailing or two (2) days after faxing or uploading the application.

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. Scheduling an assessment once your completed application has been received. You will be notified of the eligibility determination no later than 21 days following your scheduled assessment.

Call Metro to schedule your assessment. If Metro cannot schedule the assessment within 10 days of your request or your eligibility is not determined by 21 days after your assessment, you may receive Presumptive Eligibility. Presumptive Eligibility permits you to use Call-A-Ride or ATS services until your eligibility is determined. If Metro did not cause the delay, you do not receive Presumptive Eligibility. Call (314) 982-1510 to learn more about Presumptive Eligibility.

If you require transportation to and/or from your assessment appointment, Transit Access Center Staff will arrange your ride(s). Staff will notify you one (1) to three (3) days in advance of your appointment with approximate pick up time.

You may verify that transportation has been arranged and obtain your pick up time by calling Metro's Call-A-Ride Customer Assistance line at (314) 289-5230 (Missouri residents) or Alternative Transportation Service (ATS) at (618) 239-0749 (Illinois residents).

To cancel your assessment appointment, please contact the Transit Access Center at (314) 982-1510 and notify Call-A-Ride or ATS, if applicable.

Please keep this page for future reference

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ADA Paratransit Application General Information

Current or previous Call-A-Ride ID card number: ____________________________

Expiration Date: _______/________/_______ SSN: ________ – ______ – ________

First Name: _____________________ Last Name: _____________________ MI: ___

Address: ____ Apt#: ___________

City: ______________________________ State: __________ Zip: ________________

Cell Phone: (___________) ______________________________ TTY: ☐ Yes ☐ No

Home Phone: (___________) ____________________________ TTY: ☐ Yes ☐ No

Birth Date: _______/________/_______ Gender: ☐ Male ☐ Female ☐ Non-Binary

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: _____________________

Cell Phone: (___________) ______________________________

Home Phone: (___________) ____________________________

Did anyone assist you with completing this form? ☐ Yes ☐ No

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

Name: __________________________________ Relationship: __________________

Day Phone: (___________) ______________________________

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Applicant's Certification

For Applicant:

I understand that the purpose of this application is to determine my eligibility to use ADA Paratransit Services. 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: ______/______/______

Only complete if you are a legal guardian OR the applicant is less than 18 years old:

As the applicant's parent and/or legal guardian, I understand the purpose of this application is to determine if the applicant is eligible to use ADA Paratransit Services. I certify that the information provided in this application is accurate and I understand that the applicant must be present for the interview and functional assessment of his or her abilities.

I understand that if the applicant travels to the assessment on ATS or Call-A-Ride, the driver or assessment office staff will not supervise them. If these issues cause concern, they may bring an attendant at no charge. I understand that I may be present with the Applicant during the interview and any functional assessment.

Signature of Parent or Legal Guardian: ___________________________

Relationship to applicant: ______________________ Date: ___/___/___

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Information About Your Disability And Mobility Equipment

1. Please describe your disability/disabilities/health condition/diagnosis that prevent you from using MetroBus or MetroLink in more detail:

   ____

   ____

2. Do you or will you need the assistance of another person to travel while using Call-A-Ride/ATS? ☐ Yes ☐ No ☐ Sometimes

3. Please indicate all of the mobility devices or equipment you use when traveling outside your home:

☐ Communications Device
☐ Cane
☐ Powered Wheelchair
☐ Crutches
☐ Leg braces
☐ Service Animal
☐ Long White Cane
☐ Manual Wheelchair
☐ Scooter
☐ Walker
☐ Prosthesis
☐ None

☐ Other: ____

You will be assessed with the primary mobility device/aid that you bring to the eligibility center at the time of your appointment. If you change your mobility device following your evaluation, you may be required to return for a new evaluation in your new device. Use of a different mobility device may change your functional ability to use accessible fixed route transit.

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Information About Your Current Use Of MetroBus And MetroLink

This section does not pertain to Call-A-Ride/ATS, but your use of MetroBus (accessed at designated bus stops) and MetroLink (accessed at a designated train station).

1. How often do you currently use MetroBus or MetroLink services by yourself?
   ☐ Daily ☐ Several times per week ☐ At least monthly ☐ Rarely ☐ Never

2. If you currently use MetroBus or MetroLink, where do you go?

   ____

   ____

3. If you do not currently use MetroBus or MetroLink, please check all that apply:
   ☐ The closest stop is too far from my house.
   ☐ I do not know how to ride the bus or MetroLink.
   ☐ I cannot travel by myself between the bus stop and my destination.

   ☐ Other ______________________________________

4. Review and check all those that best describe your ability to use Metro services by yourself.
   ☐ I use MetroBus or MetroLink for some trips, but sometimes there are barriers that prevent me from using these services.
   ☐ I use the bus or train frequently, on routes to familiar destinations.
   ☐ I use the bus or train to go to new places.
   ☐ I believe I could use the bus or train if someone taught me.
   ☐ I am not able to use the bus or train by myself.
   ☐ The severity of my disability changes from day to day. I ride the bus or train when I am feeling well.
   ☐ I can get to and from the bus stop if the distance is not too great.

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Your Functional Ability

For each question, select only one answer. Your answers should be based on your physical and mental ability to perform the tasks.

Without the help of someone else and using a mobility aid if needed, can you:

1. Use your cellphone to get information?
   ☐ Yes ☐ No ☐ Sometimes

2. Understand directions needed to complete a trip?
   (This does not include being unaccustomed to the English language.)
   ☐ Yes ☐ No ☐ Sometimes

3. On a good day, travel without your mobility device?
   ☐ Yes ☐ No ☐ Sometimes

4. Wait at a bus stop without a seat?
   ☐ Yes ☐ No ☐ Sometimes

5. Wait at a bus stop if there was a bench or bus shelter?
   ☐ Yes ☐ No ☐ Sometimes

6. Cross the street?
   ☐ Yes ☐ No ☐ Sometimes

7. Step on and off a curb from a sidewalk?
   ☐ Yes ☐ No ☐ Sometimes

8. Find your own way to or from a transit stop?
   ☐ Yes ☐ No ☐ Sometimes

9. If the weather is good, how far can you walk or roll outside independently (check only one)?
   ☐ To the curb outside your house or apartment
   ☐ To the corner of your block
   ☐ To the nearest bus stop or train stop
   ☐ To the local store(s)
   ☐ Not sure

   ☐ Other ______________________________

10. Please use this space to further explain your travel challenges and ability to use MetroBus 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.

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Professional Verification

(Completed by your healthcare provider)

Dear Professional:

You are being asked by ____ (applicant)

DOB: ______/______/______ SS# (last 4 digits): ________________ to provide information regarding their ability to use the Metro transit system. The American with Disabilities Act is very specific on who qualifies for curb-to-curb transportation services, as opposed to riding our fixed route system. Because of your professional relationship with this applicant, you are uniquely qualified to help clarify his or her functional abilities and limitations.

> To qualify for ADA Paratransit services, a person must be unable to use regular fixed-route transit some or all of the time. On the following pages, indicate the nature of the applicant's disability.

Common Questions To Consider:

1. Does this disability prevent the applicant from following directions/navigating in the community/travel in various weather conditions/travel in complex facilities?
2. What about their disability prevents them from doing the above?

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For All Applicants

Applicant Name: ________________________________ DOB: ____/____/____

In what capacity do you know this individual? ____________________________

How long have you known this individual? ________________________________

Primary disability and/or health condition (Please include DSM-V or ICD 10 codes, if available):

____

1. Date of onset: ______/______/______
2. Prognosis: ____
3. Expected duration of condition: _____________________________________
4. Are the effects of the disability variable? ☐ Yes ☐ No
5. Is the applicant's condition well controlled with medication? ☐ Yes ☐ No
6. How does this disability prevent applicant from using MetroBus or MetroLink?

   ____

Secondary disability and/or health condition (Please include DSM-V or ICD 10 codes, if available):

____

1. Date of onset: ______/______/______
2. Prognosis: ____
3. Expected duration of condition: _____________________________________
4. Are the effects of the disability variable? ☐ Yes ☐ No
5. Is the applicant's condition well controlled with medication? ☐ Yes ☐ No
6. How does this disability prevent them from using MetroBus or MetroLink?

   ____

Can the applicant travel in the community without the assistance of another person? ☐ Yes ☐ No

What weather conditions affect the individual's ability to travel independently?
☐ Hot ☐ Cold ☐ Rain ☐ Wind ☐ Snow ☐ Ice ☐ Humidity ☐ Not applicable

☐ Other: ____

Your Name/Title: ____

Agency/Company Name: ____

Professional License # (if applicable): ____________________________

Office Address: ____

____

Office Phone: (______) __________________ Fax: (______) __________________

Your professional area of specialization is **(check one):**
☐ Audiologist
☐ Rehabilitation Specialist
☐ Physician
☐ Optometrist
☐ Physician Assistant
☐ Social Worker
☐ Registered Nurse/Licensed Practical Nurse
☐ Physical/Occupational/Speech Therapist
☐ Orientation & Mobility Specialist
☐ Psychologist
☐ Case Manager

☐ Other: ____

I hereby certify that the above information is true.

Signature: ____________________________________ Date: ______/______/______

Metro may verify the validity of the professional providing the certification and make the final determination on an applicant's eligibility for ADA Paratransit Service.

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For Applicants With An Epilepsy Condition

☐ This section does not apply.

Date of onset: ______/______/______ Date of last seizure: ______/______/______

Frequency **(check one)**

☐ 0–1 seizure/month ☐ 2–4 seizures/month ☐ 5+ seizures/month

☐ Other: ____

Type: **(Please check all that apply)**

☐ Tonic Clonic ☐ Petite Mal ☐ Focal seizures

☐ Other: ____

Does applicant lose consciousness during seizure? ☐ Yes ☐ No

Does the applicant experience an aura prior to seizure? ☐ Yes ☐ No

Are the seizures well controlled with medication? ☐ Yes ☐ No

The extent of the disability affects independent travel: ______________________

____

For Applicants With Cognitive or Psychiatric Disabilities

☐ This section does not apply.

For applicants with cognitive or psychiatric disability, on their own, can they:

Deal with unexpected situations or changes in routine? ☐ Yes ☐ No

1. Ask for, understand, and follow directions? ☐ Yes ☐ No
2. Safely and effectively travel through crowded and/or complex facilities?
   ☐ Yes ☐ No
3. Please list any activity or environmental precautions: ______________________

   ____

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For Applicants Who Have A Cardiac Condition

☐ This section does not apply.

American Heart Association Heart Failure Classification **(check one):**
Impact of physical activity on their functional abilities: ☐ I ☐ II ☐ III ☐ IV

Precautions regarding activity: ____

____

Precautions regarding extreme heat and cold (in terms of activity level, as well

as tolerance to sitting/waiting): ____

____

For Applicants With Blindness Or Low Vision

☐ This section does not apply.

Best Corrected Vision: ________ /________ OS ________ /________ OD

Visual Field: ___________ degrees

Vision is worse during these conditions **(check one):**
☐ Bright sun ☐ Low light ☐ Darkness

Individual has: ☐ No vision ☐ Night blindness ☐ N/A