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(402) 341-0800 ▫ Fax: (402) 342-0949 ▫ TDD: (402) 341-0807
Owned by the Transit Authority, City of Omaha

ADA PARATRANSIT ELIGIBILITY APPLICATION AND INSTRUCTIONS

Dear Customer:

Thank you for inquiring about eligibility for our "ADA Paratransit" service. Enclosed is a copy of an ADA Paratransit Application Form. **Please read this and the enclosed material carefully before completing the application.**

The Americans with Disabilities Act of 1990 (ADA) requires Metro to provide equivalent public transportation to individuals with disabilities that cannot board, ride or get to an accessible fixed-route bus due to their disability. This service must be comparable to the service that is provided to individuals without disabilities. The law is very specific as to whom and under what circumstances eligibility may be granted to use Paratransit transportation. Paratransit eligibility is not automatically assumed because of a disability.

You or your designee must completely answer all questions. A detailed explanation of how your disability makes it functionally impossible for you to use an accessible bus is required and you must certify that information is complete and correct by signing and dating. You will also find a Medical/Professional Verification form to be completed by your physician or medical agency. ***Please complete your application as thoroughly as possible.*** The questions will assist us in determining the specific limitations you have in using our service.

It will be necessary for a licensed medical professional (not a relative or friend) that sees you on a professional basis to complete the Medical verification portion of your application. This person may be a registered nurse, social worker, physician, physical therapist, psychologist, occupational therapist, chiropractor, speech pathologist, physician's assistant, nurse practioner, or mental health counselor employed by a medical facility. Contact our office if assistance is needed in completing your application.

BOTH THE CLIENT AND MEDICAL PROFESSIONAL VERIFICATION FORM MUST BE COMPLETED AND SUBMITTED TOGETHER. IF ANY SECTIONS ARE LEFT BLANK THE APPLICATION WILL BE RETURNED TO YOU AS INCOMPLETE AND IT WILL DELAY THE CERTIFICATION PROCESS.

The information you provide in this application is confidential

All applicants, whether new or persons applying for recertification, must complete a new application. The ADA certification process may involve an in-person interview and/or functional assessment to determine your abilities to use Metro's fixed-route service.

MOBY PARTICIPATION AND RELEASE OF LIABILITY AGREEMENT

1. Applicant's Name:_____

2. I declare that the applicant is capable of riding MOBY without being a danger to himself/herself, other passengers or because of his/her youth.

3. I agree that a personal care attendant to accompany the applicant is necessary if the client is not alert enough to be aware of surroundings due to physical and /or mental handicap.

4. If the applicant requires a personal care attendant, the care-provider / legal guardian must provide a responsible adult to accompany the applicant to and from the destination. The attendant will not be charged for the trip.

5. I agree to inform MOBY about any changes in equipment prior to scheduling of rides. If the applicant changes to equipment which provides less assistance (example: from wheelchair to walker) a doctor's certificate is to be given to MOBY including the appropriateness, or reason, the new equipment is to be used.

6. I agree to inform MOBY about any change that makes the applicant ineligible for MOBY services.

7. Release of liability: It is understood by the undersigned applicant/applicant representative that MOBY, its officers, employees and their successors, insurers and assignees are released from liabilities and shall be held harmless from any and all law suits, claims, losses, liabilities or damages due to personal injuries or property damage to a client cause by his/her mental or physical disability, to and from his/her door to the vehicle, and to and from his/her destination.

8. The undersigned agrees to and will follow all of the conditions of this agreement.

Signed: _____ Date: _____

Printed Name of Applicant: _____

Signature of Parent or Legal Guardian:

_____ Date: _____

Print Name _____

Relationship to Applicant _____ Phone _____

About Your Disability

1. What type or types of disabilities prevent you from using standard bus service (check all that applies?)

[ ] physical disability
[ ] developmental disability
[ ] other
[ ] visual impairment/blindness
[ ] mental illness
[ ] none

2. Are the conditions you described? [ ] Permanent [ ] Temporary

If temporary, how long do you expect to have this disability? _____/_____/_____ (Date)

3. Which of the following mobility aides, if any do you use to help you get where you need to go?

(Please check all that apply.)

[ ] cane
[ ] long white cane
[ ] portable oxygen
[ ] walker
[ ] crutches
[ ] extra-large wheelchair
[ ] power wheelchair
[ ] manual wheelchair
[ ] power scooter/cart
[ ] service animal
[ ] prosthesis
[ ] communication board
[ ] other _____
[ ] none

4. Do you use a manual or power wheelchair or scooter? [ ] Yes [ ] No

How wide is it? _____ inches How long is it? _____ inches

How much does your wheelchair or scooter weigh when in use _____ pounds.

5. Are you able to wait 15 minutes at a public stop with your mobility device?
[ ] Yes [ ] No [ ] Sometimes - **If "No" or "Sometimes", please explain:**

_____

_____

6. Can you transfer from your wheelchair to a seat in a vehicle? Yes _____ No _____

7. Are you sensitive to heat? [ ] Yes [ ] No

If yes, please explain:

_____

Traveling To and From Bus Stops

1. Are you able to recognize printed information?
[ ] Yes [ ] No [ ] Sometimes - **If "No" or "Sometimes", please explain:**

_____

_____

2. Are you able to cross streets by yourself?
[ ] Yes [ ] No [ ] Sometimes - **If "No" or "Sometimes", please explain:**

_____

_____

3. Are you able to travel or get around by yourself after dark? [ ] Yes [ ] No
[ ] Sometimes - **If "No" or "Sometimes", please explain:**

_____

_____

4. Are you able to travel by yourself along sidewalks and other pedestrian ways?
[ ] Yes [ ] No [ ] Sometimes - **If "No" or "Sometimes", please explain:**

_____

_____

5. Are you capable and comfortable getting around in a store or shopping mall by yourself?
[ ] Yes [ ] No [ ] Sometimes - **If "No" or "Sometimes", please explain:**

_____

_____

6. Under the best of conditions what is the farthest you can walk (or travel using your mobility aid) without the help of another person?

[ ] Less than 1 block
[ ] 1 block
[ ] 2 blocks (1/4 mile)
[ ] 4 blocks (1/2 mile)
[ ] 6 blocks
[ ] More than 6 blocks
[ ] I cannot travel outdoors alone

7. Are you able to detect curbs and other drop offs? [ ] Yes [ ] No [ ] Sometimes
If "No" or "Sometimes", please explain:

_____

_____

14. Could you wait if there were a seat or bus shelter? [ ] Yes [ ] No
[ ] Sometimes - **If "No" or "Sometimes", please explain**:

_____

_____

15. Could you wait if there was not a seat or bus shelter? [ ] Yes [ ] No
[ ] Sometimes - **If "No" or "Sometimes", please explain**:

_____

_____

16. Could you pay the fare by putting coins or tickets in the fare box, or by showing a pass to the bus driver? [ ] Yes [ ] No [ ] Sometimes
If "No" or "Sometimes", please explain:

_____

_____

17. Are you able to independently call and make or cancel trip reservations?
[ ] Yes [ ] No - **If "No", please explain:**

_____

_____

18. Can you wait alone at you residence and places to which you travel?
[ ] Yes [ ] No- **If "No", please explain:**

_____

_____

19. Could you independently ride in a taxi if one were provided?
[ ] Yes [ ] No- **If "No", please explain:**

_____

_____

Boarding and Exiting the Bus

1. Do you now use regular route service?
[ ] Yes [ ] No [ ] Sometimes **Please explain:**

_____

_____

2. Are you able to recognize changes in your mental/emotional state that prevents you from using regular route service? [ ] Yes [ ] No [ ] Sometimes
If "No" or "Sometimes", please explain:

_____

_____

3. Do you have to go up and down steps in your home or residence?
[ ] Yes [ ] No [ ] Sometimes - **If "No" or "Sometimes", please explain:**

_____

_____

4. Can you safely and independently walk up and down three (3) 12 inch steps?
[ ] Yes [ ] No [ ] Sometimes - **If "No" or "Sometimes", please explain:**

_____

_____

5. Are you able to board, ride, or exit a wheelchair accessible bus without assistance?
[ ] Yes [ ] No [ ] Sometimes - **If "No" or "Sometimes", please explain:**

_____

_____

Release of Information

I, the applicant, understand that the purpose of this application is to determine my eligibility to use Metro (MOBY) paratransit service. I hereby authorize my health care professional to release information about my disability and its affect on my ability to travel, which may be needed in connection with my request for ADA paratransit eligibility certification.

I agree to notify Metro (MOBY) paratransit service of any changes in status of my disability that affects my ability to use paratransit service. I hereby certify that the information in this application is true and correct. I understand that falsification of the information may result in denial of service. I understand all information will be kept confidential and only the information required providing the service I request will be disclosed

I hereby certify that I am the individual requesting certification for ADA paratransit service and that all information contained in this application is true and accurate:

Signed: _____ Date: _____

Printed Name of Applicant: _____

If the applicant is a minor or has a legal guardian the parent or guardian must sign this Application, and attest to the accuracy of the information contained herein.

Signature of Parent or Legal Guardian:

_____ Date: _____

Relationship to Applicant _____ Phone _____

The next part of the application must be filled out by a health care or human services professional who is familiar with the applicant's disabling condition and/ or functional limitation.

In the space provided below, CLEARLY PRINT the name of the Professional who will be verifying your application, and specify his/her position.

Name of professional _____

Professional affiliation:

[ ] licensed physician
[ ] licensed occupational therapist
[ ] nurse (LPN or RN)
[ ] certified rehabilitation
[ ] vision specialist
[ ] Psychiatrist, psychologist or mental health counselor
[ ] licensed physical therapist
[ ] licensed social worker
[ ] certified psychologist
[ ] speech pathologist
[ ] orientation/ mobility specialist
[ ] audiologist/ hearing specialist
[ ] ophthalmologist

Physician's Verification of Disability

THIS PORTION OF THE FORM MUST BE COMPLETED AND SIGNED BY AN APPROPRIATE MEDICAL, CERTIFIED OR LICENSED PROFESSIONAL WHO IS TREATING THE APPLICANT

Dear Health Care Professional:

The Americans with Disabilities Act of 1990 (ADA) requires public transit agencies to provide paratransit service to people whose disabilities prevent them from using a bus some or all of the time. Disability alone and distance to and from a bus stop **DO NOT**, by themselves, qualify a person for MOBY. Inconvenience and/or decreased comfort **ARE NOT** a basis for qualification. The client's condition must **PREVENT** travel by bus. The information you provide will enable us to make an appropriate determination for this applicant. All information will be kept confidential. *Thank you for your assistance.*

Client Name _____

Please do not list "diagnosis" as the reason the applicant needs paratransit curb to curb service. We need detailed information about how the condition or disability makes it functionally impossible for the applicant to utilize our city buses. Our evaluation is a transportation decision, not a medical authorization.

The law is very specific as to whom and under what circumstances eligibility may be granted to use MOBY paratransit transportation:

As of January 2001 all Metro city buses have ACCESSIBLE features:

- All are equipped with wheelchair lifts or ramps, along with securement devices.
- Most buses have a kneeling capability. (Can be lowered to provide easier boarding)
- Approximately 30% of the buses have only one step up from the curb.
- Bus operators announce transfer points and all requested stops.
- Customer Service phone line(s) are available to provide bus schedule information and assist customers with their trip routing, including transfers between bus routes.

MOBY
341-0800
FAX (402) 342-0949
2222 CUMING STREET
OMAHA, NEBRASKA 68102-4392

7. Does the applicant have any other medical condition of which MOBY should be aware? If yes, describe:

_____

_____

8. Please describe the impact this disability/condition has on the applicant's ability to use the city buses:

_____

_____

9. How far can the applicant walk without assistance? Please check.

[ ] The length of one football field? (300 feet)

[ ] Less than one city block? (500 feet)

[ ] One length of a football field and back? (600 feet)

[ ] One lap around a track? (1,320 feet)

10. Does the applicant use a mobility device? Please check all that apply.

[ ] cane	[ ] extra-large wheelchair	[ ] prosthesis
[ ] long white cane	[ ] power wheelchair	[ ] communication board
[ ] portable oxygen	[ ] manual wheelchair	[ ] none
[ ] walker	[ ] power scooter/cart	[ ] other _____
[ ] crutches	[ ] service animal	

11. How far can the applicant travel using a mobility device? Please check

[ ] The length of one football field? (300 feet)

[[Less than one city block? (500 feet)

[ ] One length of a football field and back? (600 feet)

[ ] One lap around a track? (1,320 feet)

Does The Applicant Require A Personal Care Attendant/Assistant When Traveling? [ ] Yes [ ] No

A Personal Care Attendant (PCA) is not a companion or escort, but someone who will be helping the client with his/her mobility assistance, personal care, communication, transportation, sign language interpretation, providing services as a reader, etc., as the client makes his/her trip.

Visual Impairment Verification (Not a request for copies of medical records)

Capacity in which you know the applicant

_____

Date of applicant's last visit _____/_____/_____

Please describe the applicant's disability/condition in layman's terminology:

_____

_____

What is the applicant's best corrected" vision in each eye?
Right Eye: 20/____ Left Eye: 20/_____

How long has the applicant had this visual impairment? _____

Is the applicant's visual impairment permanent? [ ] Yes [ ] No]

Is the applicant's visual impairment affected by various lighting conditions? [ ] Yes [ ] No

If Yes, Describe: _____

_____

Is the visual impairment affected by weather? _____ Yes No _____

If Yes, Describe: _____

Field Restriction: [R] _____ [L] _____ Date of testing:_____

CERTIFICATION:

I certify that the information I have provided herein is a fair representation of this applicant's medical impairment or condition and is accurate to the best of my knowledge. I understand that the information provided hereto will be used for the sole purpose of determining the applicant's eligibility for paratransit services. I also agree that Metro may contact me for clarification of any information I have provided and I will reply in good faith. I certify that the information contained herein is true and correct to the best of my knowledge and ability.

Health Care Professional Completing Form: _____
(NAME)

Medical License Number _____ Telephone# _____ Fax# _____

Institution/Facility/Agency Name _____

Street _____ City _____ State _____ Zip Code _____

Signature of Health Care Professional _____ Date _____