COLORADO SPRINGS
OLYMPIC CITY USA

metro
MOUNTAIN METROPOLITAN TRANSIT
TRANSIT SERVICES

Dear Metro Mobility Applicant,

Thank you for your inquiry regarding ADA eligibility for Metro Mobility Paratransit Services. Paratransit service is available to those individuals with disabilities who are prevented from using Mountain Metropolitan Transit, the fixed-route bus service, some or all the time. Eligibility is determined by application and an in-person evaluation.

The accompanying application is designed to gather information regarding the applicant's disability and how it prevents them from using the fixed-route bus service. The applicant's own assessment of their environment and functional ability to use the fixed-route bus is very important to this process. Additional professional information (doctor or therapist letter, etc.) included with the application is incredibly helpful; however, it is not required.

The ADA paratransit eligibility evaluation is completed in person. It is an evaluation process to determine the applicant's ability to use public transportation. The guidelines for eligibility are the following:

1. If you cannot independently negotiate the fixed-route service due to a disability.
2. If the fixed-route bus is not accessible to you and the equipment you use due to a disability.
3. If you are unable to travel to or from a bus stop or wait a reasonable period of time at a bus stop due to a disability.

ADA eligibility is a transportation decision, **not** a medical one. Eligibility is not based on a letter from the Social Security Administration, your age, financial resources, an inability to drive, or convenience. Disability alone does not guarantee eligibility.

Eligibility determination outcomes can either be conditional or unconditional, a temporary certification (less than three years) or a three year certification, or a denial of service. If conditional, the conditions for use will be explained at the certification evaluation and listed on your ADA eligibility determination letter. All customers are required to recertify prior to the end of their certification term. Recertification reminder

letters will be sent to the address on file approximately two months prior to certification expiration.

Applications are reviewed by Metro Mobility Eligibility staff. Incomplete applications may be returned if additional information is needed. A call is then made to the applicant (or representative) by the office staff to set up an appointment. A call to the applicant is made within three business days of receiving the application. Metro Mobility will provide a ride to and from the Certification Office free of charge within Metro Mobility's service area. If the applicant lives outside of Metro Mobility's service area and needs a ride, an attempt will be made to schedule a ride through the One-Ride Call Center.

Applicants may expect up to 21 days from the time a complete application is submitted to complete the rest of the eligibility process. If Metro Mobility Eligibility staff cannot make an eligibility determination within 21 days, through no fault of the applicant, the applicant will be given presumptive eligibility until a determination can be made. In situations where the applicant must use One-Ride Call Center, the application process may take longer than 21 days to complete.

Thank you for your interest in using Metro Mobility. We look forward to meeting with you!

Sincerely,

Jacob Matsen,
ADA Paratransit Coordinator

*Date Recv'd:* _____
(Office use only)

# Application for Metro Mobility
# ADA Paratransit Service

**APPLICANTS:** All questions must be filled out COMPLETELY. Please read the instructions carefully. SIGN and DATE this application on page 5.

*For the following questions, please print your answers legibly.*

Name: _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (Zip Code)

Phone: _____ Cell Phone: _____

Email:_____

Date of Birth: _____

Did you complete this application by yourself?

- ☐ Yes
- ☐ No (If no, the person helping you complete the application needs to complete Part B of the certification on page 5.)

If different from the applicant, please give the name and phone number of the person who can arrange an interview /evaluation appointment for the applicant.

Name: _____ Phone: _____

Please list a person who lives locally that could be contacted in an emergency:

Name: _____ Relationship: _____

Daytime Phone: _____ Evening Phone: _____

Please attach all relevant information identifying your disability and include any appropriate documentation to this application. (Use extra pages, if necessary.) **You will need to include a letter from your doctor, agency, or professional that can verify your functional ability as it relates to the fixed-route city bus.**

1. Describe the disability or condition which you believe *may* make you eligible for Metro Mobility ADA Paratransit Service.

_____
_____
_____
_____
_____
_____
_____

2. Please explain how your disability prevents you from riding the fixed-route, city bus service:

_____
_____
_____
_____
_____
_____

3. A. What mobility aid or equipment do you use when you travel? (Check all that apply)

- ☐ Wheelchair
- ☐ Walker
- ☐ Portable Oxygen
- ☐ Cane
- ☐ Leg Braces
- ☐ Service Animal
- ☐ Other: _____

**If you use a wheelchair, please answer 3B through 3D.**

B. What type of wheelchair is it?

- ☐ Manual
- ☐ Power
- ☐ Scooter

C. What is the combined weight of you and your wheelchair?

- ☐ Under 600 pounds
- ☐ 600 pounds or more

D. Please provide us with the approximate dimensions and the make and model of your wheelchair:

Length: _____ Inches

Width: _____ Inches

Make/Model: _____

4. Do you require the assistance of a personal care attendant?

   □ Yes

   □ No

5. Can you travel to and from the curb in front of your house without assistance?

   □ Yes

   □ No

6. Are there any physical or terrain barriers (i.e. streets, sidewalks or curbs) that prevent you from getting to or from a bus stop?

   □ Yes

   □ No

   If yes, please describe what type of barriers you face and how they prevent you from reaching the bus stop:

   _____

   _____

   _____

   _____

7. How far is the nearest bus stop to your residence? _____

8. What bus route(s) is nearest to your residence? _____

9. When riding the fixed-route, city bus:

| | |
|---|---|
| Are you able to ask the driver for assistance? | □ Yes<br>□ No |
| Can you grasp railings to get on and off the bus? | □ Yes<br>□ No |
| Can you pull cords, or push the bell strip in order to let the driver know you want to get off a bus? | □ Yes<br>□ No |

Are you able to count out your fare and hand it to the bus driver?

- ☐ Yes
- ☐ No

10. If you were provided with travel training and given information about the fixed-route, city bus service and routes, do you think you would be able to use the bus independently or with assistance?

    - ☐ Yes
    - ☐ No
    - ☐ Sometimes

11. Please provide any other information which will assist us in understanding your level of mobility:

    _____
    _____
    _____
    _____
    _____
    _____

12. Do you need bus information provided in an alternate format?

    - ☐ Yes
    - ☐ No

    If yes, check all formats that you can use:

    - ☐ Braille
    - ☐ Large Print
    - ☐ Other: _____

**Please review your application to make sure every question has an answer. Once you have done so, please sign and date the application on the next page:**

**In signing this application, the applicant agrees to the following conditions:**

1) An interview will be required in addition to a completed application.
2) If at any time the applicant no longer has the disability as described, their eligibility for paratransit services automatically ceases and they will no longer be eligible to use Metro Mobility service.
3) Falsification of information in this application will result in a denial of service.
4) All information provided in this application will be kept confidential. Only the information required to provide the services the certified individual requests will be disclosed to those who perform those services.
5) An individual who is found ineligible for Metro Mobility services may appeal the decision within 60 days of a written determination, and they will be advised of the appeals procedures.

**A. Applicant Signature**

I certify the information given in this application is true and correct. I authorize Metro Mobility to contact by phone or by letter any agency or professional that I have indicated on this form in order to verify documentation of my functional ability.

Applicant Signature: _____ Date: _____

**B. Person completing form if other than applicant (please check one):**

- ☐ I certify that the information provided in this application is true and correct, based upon information given to me by the applicant.
- ☐ I certify that the information provided in this application is true and correct based upon my own knowledge of the applicant's health condition or disability.

Name: _____ Phone: _____

Relationship: _____

Signature: _____ Date: _____

**Please return this application in one of the following ways:**

**Mail:** 1015 Transit Drive, Colorado Springs, Colorado 80903
**Email:** metrocertifications@springsgov.com
**Fax:** 719-385-5419

# Medical Release

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED MEDICAL, DEVELOPMENTAL AND MENTAL HEALTH INFORMATION

Please complete all sections

I, _____ authorize _____
(Applicant Name) (Name of Professional with Title)

Professional's Address: _____

Professional's Phone: _____ FAX: _____

to disclose Protected Health Information (PHI) to the Mountain METRO Mobility (ADA Paratransit) Program, 1015 Transit Drive Colorado Springs, CO 80903, for the purpose of assessing whether I am eligible under the Americans with Disabilities ACT for Mountain METRO Mobility's (paratransit) transportation service.

My PHI may include medical records, diagnostic reports, physical therapy/occupational therapy/other therapy records, and any personal, medical, cognitive, or mental health related information pertinent to my application for Mountain METRO Mobility eligibility. If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my initials in the space next to the type of information:

_____ Chemical dependency
_____ Sexually transmitted diseases
_____ HIV/AIDS
_____ Genetic information
_____ Mental health information (excludes psychotherapy notes)
_____ Reproductive health (including abortion)

I may cancel this authorization at any time by sending a written request to the Mountain METRO Mobility paratransit program, 1015 Transit Drive Colorado Springs, CO 80903. My cancellation of this authorization will not affect any uses or disclosures made before my request is received. If I do not revoke this authorization, it will automatically expire in 90 days.

I understand that I am not legally obligated to sign this authorization and that Mountain METRO Mobility will not refuse to accept my application for Mountain METRO Mobility eligibility based on my refusal to sign this authorization. I also understand that if Mountain METRO Mobility is unable to obtain information necessary to determine my disability or health condition and how the disability or health condition limits or prevents my use of the regular, fixed-route bus services, my application for Mountain METRO Mobility eligibility may not be processed or may be denied.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be legally protected. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information genetic information and drug/alcohol information.

I understand that by signing this statement I am authorizing Mountain METRO Mobility to provide a copy of this statement to the above listed professional for the purposes of compliance with the Health Insurance Portability and Accountability ACT (HIPAA).

_____
Signature of applicant or legal representative Date

Applicant Date of Birth: _____

# Paratransit Eligibility Professional Verification

**TO BE COMPLETED BY A PROVIDER, PROFESSIONAL OR SPECIALIST IN THE AREAS OF MEDICAL, DEVELOPMENTAL, AND/OR MENTAL HEALTH.**

PLEASE FAX THIS COMPLETED PROFESSIONAL VERIFICATION TO: **(719) 385-5419**

**Please complete all sections and check responses where applicable.**

| | |
|---|---|
| Applicant's Name: | Applicant's DOB: |
| Professional's Name and Title: | Relationship to Applicant: |
| How long have you treated this applicant? | Date of your last in-person contact: |

**CONDITIONS/DIAGNOSES** List any condition/diagnosis (with ICD-9, ICD-10 or DMS-IV codes) which affect the applicant's physical and/or cognitive ability to *independently* navigate the fixed-route, public transit system. Please attach additional information/records, as needed.

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Condition/Diagnosis: | | | | | | | | | Date of Onset: | | |
| Condition is considered: | | Mild | | Moderate | | Severe | | Profound | | | |
| Prognosis: | | Permanent | | Progressive | | Temporary (with Expected Duration): | | | | | |
| 2. Condition/Diagnosis: | | | | | | | | | Date of Onset: | | |
| Condition is considered: | | Mild | | Moderate | | Severe | | Profound | | | |
| Prognosis: | | Permanent | | Progressive | | Temporary (with Expected Duration): | | | | | |
| 3. Condition/Diagnosis: | | | | | | | | | Date of Onset: | | |
| Condition is considered: | | Mild | | Moderate | | Severe | | Profound | | | |
| Prognosis: | | Permanent | | Progressive | | Temporary (with Expected Duration): | | | | | |

**TYPE OF DIAGNOSIS** Check all which apply and provide requested information.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Physical | Type of Testing: | | Date: | | Score: | |
| | Cognitive/Developmental | Type of Testing: | | Date: | | Score: | |
| | Mental Health | Type of Testing: | | Date: | | Score: | |
| | Visual Acuity | | Corrected with: | | Not corrected | Right Eye: | Left Eye: |
| | Seizure Activity | Type: | | Date of Last Sz: | | Frequency: | |

**MEDICATION** Check all which apply and provide requested information.

Type of Medication Applicant is Prescribed:

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Pain (class 1, 2 or 3) | | Cardio/Pulmonary | | Mental Health | | Anticonvulsant/Antispasmodic | | Other: | | |
| Do you deem the applicant to be compliant in taking medication? | | | YES | | NO | | | | | | |
| To what degree does medication mitigate related Sx? | | | | | | | | | | | |
| Has the applicant's functional ability changed temporarily due to medication adjustment? | | | | | | | | YES | | NO | |
| If yes, please explain and give expected duration: | | | | | | | | | | | |
| What, if any, adverse effects of prescribed medication are related to independent travel on public transit? | | | | | | | | | | | |

**ABILITY** Check all which apply to any function effected by the applicant's disability. Add other functions effected in empty boxes.

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Gait | | Emotional | | Problem-Solving | | Memory: | | Short-Term | | Long-Term |
| | Balance | | Concentration | | Coping Skills | | Judgment | | | | |
| | Communication | | Disorientation | | Monitoring Time | | Over-Friendly | | | | |
| Inappropriate social behaviors? | | | | | Sexual | | Aggressive | | | | |
| What, if any, limitations regarding independent travel on public transit have been communicated with the applicant? | | | | | | | | | | | |
| Is the goal of independent travel on public transit within the context of treatment for this applicant? | | | | | | | | | | YES | NO |
| Would training on how to use public transit be appropriate for this applicant? | | | | | | | | | | YES | NO |

**I CERTIFY THAT THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY ABILITY AND KNOWLEDGE.**

| | |
|---|---|
| Print Name/Title: | Phone #: |
| Signature: | Date: |

## Fares

All passengers and companions must pay a $3.50 one-way fare as they board. Most children ages 6 to 18 are considered companions and must pay a one-way fare as they board. Only a personal care attendant traveling with an ADA-certified rider may ride free of charge.

Passengers not having the correct fare will NOT be permitted to board. If paying your fare in cash, please have correct change. Your driver cannot make change and cannot accept a check for a one-way ride.

Drivers are not permitted to access a passenger's personal wallet, purse, or backpack, nor write and/or fill in any information on a passenger's personal check. However, a driver may assist a passenger with a visual impairment write out a check by placing the pen on the line to be completed.

You may purchase 10 or 40 ride ticket books through a Metro Mobility driver or at the Transit Administration Office, located at 1015 Transit Drive, Colorado Springs, Colorado 80903.

Fare can also be paid by establishing a prepaid electronic account. Use the following steps to set up or add money to a prepaid account:

- Go to www.mmtransit.com
- Select the link, "ADA Paratransit Service" from the left side of the page
- Choose "Purchase Tickets"
- Choose "ADA Mobility Tickets"
- Under "Metro Mobility Electronic Fare", enter the quantity in $1.00 increment in the amount you wish to purchase, and select "Add to cart".
- Follow the prompts to complete your purchase.

If you have any questions or issues with the fare or adding money to your account, please contact the Customer Service Advocate at 719-392-2396, Option 3.