



Dear Applicant,

Thank you for your recent inquiry regarding ADA eligibility for Metro Mobility and Amblicab Paratransit Services. **Paratransit service is made available to those individuals with disabilities who are prevented from using Metro Transit, the fixed route bus, some of the time or all the time.** Eligibility is determined by application, interview, and a possible functional evaluation.

The application is designed to gather information regarding the applicant's disability and how it prevents them from using the fixed route bus. The applicant's own assessment of their environment and functional ability to use the fixed route bus, Metro Transit, is very important to this process. **Additional professional information (doctor or therapist letter, etc.) included with the application is helpful and in most applications 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 taken from the Department of Transportation Regulation 49 CFR, part 37:

1. **If you cannot independently negotiate an accessible Metro Transit bus due to a disability.**
2. **If the 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, trip purpose, financial resources, inability to drive, not having bus service where you live, or that bus service may not be convenient to use.

Eligibility determination outcomes can either be conditional or unconditional; temporary or permanent. If conditional, the conditions for use will be explained at the certification evaluation and listed on your ADA eligibility determination letter. Eligibility outcomes may be temporary or permanent (for a maximum of 3 years, when recertification is required). Recertification requires both a new application and evaluation.

Once the client (or representative) completes and returns the application, it is reviewed by the evaluator. 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 client is made within a week (usually less) after receiving the application. The sooner the completed application is *mailed* to the office (address is on the application), the sooner the certification process can begin. If transportation is not available to the client, Metro Mobility will provide a ride to and from the Transit Services.

Please MAIL applications or fax to:

Metro Mobility Certification Office  
1015 Transit Dr.  
Colorado Springs, CO 80903  
(719) 392-2396 ext. #5  
(719) 385-5419 Fax



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

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

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

- |                                       |                                     |  |
|---------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Wheelchair   | <input type="checkbox"/> Walker     | <input type="checkbox"/> Portable Oxygen |
| <input type="checkbox"/> Cane         | <input type="checkbox"/> Leg Braces | <input type="checkbox"/> Service Animal  |
| <input type="checkbox"/> 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:

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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

No

Can you grasp railings to get on and off the bus?

Yes

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

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:

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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](mailto:metrocertifications@springsgov.com)

**Fax:** 719-385-5419



## 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:			
<b>CONDITIONS/DIAGNOSES</b> List any condition/diagnosis (with ICD-9, ICD-10 or DMS-IV codes) which affect the applicant's physical and/or cognitive ability to <i>independently</i> 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	
Prognosis:		Permanent		Progressive		Temporary (with Expected Duration):	
2. Condition/Diagnosis:				Date of Onset:			
Condition is considered:		Mild		Moderate		Severe	
Prognosis:		Permanent		Progressive		Temporary (with Expected Duration):	
3. Condition/Diagnosis:				Date of Onset:			
Condition is considered:		Mild		Moderate		Severe	
Prognosis:		Permanent		Progressive		Temporary (with Expected Duration):	
<b>TYPE OF DIAGNOSIS</b> 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:	
Seizure Activity		Type:		Date of Last Sz:		Frequency:	
<b>MEDICATION</b> 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	
Do you deem the applicant to be compliant in taking medication?						YES	
To what degree does medication mitigate related Sx?						NO	
Has the applicant's functional ability changed temporarily due to medication adjustment?						YES	
If yes, please explain and give expected duration:						NO	
What, if any, adverse effects of prescribed medication are related to independent travel on public transit?							
<b>ABILITY</b> 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:	
Balance		Concentration		Coping Skills		Short-Term	
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	
Would training on how to use public transit be appropriate for this applicant?						NO	
<b>I CERTIFY THAT THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY ABILITY AND KNOWLEDGE.</b>							
Print Name/Title:				Phone #:			
Signature:				Date:			

# 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: \_\_\_\_\_



## **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](http://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.