2222 Cuming Street, Omaha, NE, 68102-4392
Phone: 402-346-8779 Fax: 402-342-3395
TDD: 402-341-0807

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 practitioner, 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.

If you are determined eligible for MOBY SERVICE, your eligibility will be for one of the following types or conditions:

1. **CONDITIONAL ELIGIBILITY**
   You are able to use the fixed route buses for **SOME** of your trips, and qualify for ADA Paratransit Service for other trips.
2. **UNCONDITIONAL ELIGIBILITY**
   Your disability or health condition always prevents you from using the fixed route buses and you qualify for ADA Paratransit for **ALL** of your trips.
3. **TEMPORARY ELIGIBILITY**
   You have a health condition or disability that **TEMPORARILY** prevents you from using the fixed route buses.

A determination is made based upon an individual's ability to board, ride and disembark independently from a fully accessible fixed-route vehicle. The terrain and architectural structure are also considered. It is important for all applicants to realize that this is a transportation decision, not a medical authorization.

Lack of Metro route service in an area or at specific schedule times does not qualify for MOBY eligibility. MOBY provides service within three-quarters of a mile outside of a Metro bus line where as the same routes and times of fixed-route bus services are available.

A determination of your eligibility will be made by the MOBY within 21 days of receipt of the completed application. MOBY will notify you in writing of the decision about your eligibility for ADA paratransit service. If it is determined that you are able to use the fixed route system and are not eligible for paratransit service, MOBY will explain the reason for this determination. If you are determined **Not Eligible** for MOBY service, or are dissatisfied with your eligibility type, you may appeal the decision. A written request to the **T.A.C.** board must be received within 60 days of the denial letter. Simply submit a letter stating that you wish to appeal the decision that was made and why you feel you should be eligible for MOBY service. Attach copies of any other pertinent information. The appeals recommendation is the final determination. You may only re-submit an application if your condition worsens. (MOBY) service will not be provided during the appeal process, unless the appeal process cannot be concluded within 30 days.

The **TRANSIT ADVISORY COMMITTEE'S (TAC)** Appeals Subcommittee is comprised of ten (10) persons who are local paratransit customers, transit bus customers, and other individuals who are knowledgeable of the Americans with Disabilities Act (ADA) of 1990. The Transit Advisory Committee meets monthly and has been in existence since the summer of 1972.

Appeals must be in writing and forwarded to:

Metro
Attn: Transit Advisory Committee (TAC)
2222 Cuming St.
Omaha, Nebraska 68102-4392

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 themself, other passengers or because of their 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 their mental or physical disability, to and from their door to the vehicle, and to and from their destination.

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

Signature of Applicant Date

Printed Name of Applicant

Signature of Parent or Legal Guardian Date

Printed Name of Parent or Legal Guardian

Relationship to Applicant Phone Number

APPLICATION FOR MOBY SERVICES

It is important to complete all parts of the attached form. Applications that are not fully completed or clearly written will be returned, which will delay the eligibility process. Please print.

Name:
First, Middle, Last

Mailing Address:

City: State: Zip Code:

Physical address (if different from mailing):

City: State: Zip Code:

Daytime Phone: ( ) TDD/TTY: ( )

Evening Phone: ( ) Email:

Sex: ☐ Female ☐ Male Birth Date:

Primary Language: ☐ English ☐ Other - Please specify

If this application has been completed by someone other than the applicant requesting certification, that person must complete the following:

Name:

Address:

City: State: Zip Code:

Relationship:

Phone: ( )

Please indicate if this person should be contacted directly if additional information is requested.

☐ Yes ☐ No

Emergency Contact Person(s):

Name:
(Primary Contact) Day Phone: ( )

Relationship: Evening Phone: ( )

Name:
(Secondary Contact) Day Phone: ( )

Relationship: Evening Phone: ( )

About Your Disability

1. What type or types of disabilities prevent you from using standard bus service? Check all that apply.

- ☐ physical disability
- ☐ developmental disability
- ☐ other
- ☐ visual impairment/blindness
- ☐ mental illness
- ☐ none

2. Are the conditions you described permanent or temporary? ☐ 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

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

6. 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:

8. Are you sensitive to the cold? ☐ Yes ☐ No

If yes, please explain:

9. Do other weather/lighting conditions (wind dusk/dark and or glare) affect your disability?

☐ Yes ☐ No **If yes, please explain:**

10. Is your breathing affected by weather or environmental conditions?

☐ Yes ☐ No ☐ Sometimes – **If "Yes" or "Sometimes", please explain:**

11. Does your disability change after medical treatment/medications?

☐ Yes ☐ No ☐ Sometimes – **If "Yes" or "Sometimes", please explain:**

12. Are there any other comments or additional information relating to your disability that you would like to explain or we should be aware of?

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:**

8. Are you able to reach and return from your neighborhood bus stop independently?

☐ Yes ☐ No ☐ Sometimes – **If "No" or "Sometimes", please explain:**

9. Are you able to wait outside without assistance or support for fifteen (15) minutes?

☐ Yes ☐ No ☐ Sometimes – **If "No" or "Sometimes", please explain:**

10. Are there barriers that prevent you from getting to and from the bus stop?

☐ Yes ☐ No ☐ Sometimes – **If "No" or "Sometimes", please explain:**

11. Are you able to leave and return to your regular destinations (local bus stops) independently?

☐ Yes ☐ No ☐ Sometimes – **If "No" or "Sometimes", please explain:**

12. Are you able to travel on flat surfaces in good weather?

☐ Yes ☐ No ☐ Sometimes – **If "No" or "Sometimes", please explain:**

13. Are you able to travel on slight inclines in good weather?

☐ 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 your 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:**

20. How long are you able to wait for a bus to arrive? minutes.

21. Are you able to give addresses and telephone numbers upon request?

☐ Yes ☐ No ☐ Sometimes – **If "No" or "Sometimes", please explain:**

22. Are you able to ask for, understand and follow directions?

☐ Yes ☐ No ☐ Sometimes – **If "No" or "Sometimes", please explain:**

23. Are you able to deal with unexpected situations or changes in routine?

☐ Yes ☐ No ☐ Sometimes – **If "No" or "Sometimes", please explain:**

24. Do you require the services of a Personal Care Attendant (PCA) when you travel?

(This person is not a companion or escort, but someone who will be helping you with mobility assistance, personal care, communication, transportation, sign language interpretation, providing services as a reader, etc., as you make your trip).

☐ Yes ☐ No

Please give **Personal Care Attendant** name.

Please give **Personal Care Attendant** name.

(**In order for your Personal Care Attendant to ride with you at no charge, you must inform the MOBY office staff that you will be accompanied by a Personal Care Attendant when making your ride request. The Personal Care Attendant is then responsible for assisting you, not Metro (MOBY).**

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:**

6. Are you able to grasp handles or railings while boarding or exiting a bus?

☐ Yes ☐ No ☐ Sometimes – **If "No" or "Sometimes", please explain:**

7. Are you able to board or exit a vehicle if it has a lift or kneeler that lowers the front of the bus?

☐ Yes ☐ No ☐ Sometimes – **If "No" or "Sometimes", please explain:**

8. Are you able to get on and off a bus without assistance?

☐ Yes ☐ No ☐ Sometimes – **If "No" or "Sometimes", please explain:**

9. Have you ever had training to learn how to travel around the community or how to use the fixed-route buses?

☐ Yes ☐ No

10. Is there something that might help you to ride the bus? **Please check all that apply.**

- ☐ Yes, if someone taught me to understand the route, schedule and fare information.
- ☐ Yes, if someone were to show me how to ride the bus.
- ☐ Yes, learning how to get on the bus using the lift.
- ☐ Yes, if the bus were to come closer to where I live and need to go.
- ☐ No, none of these would help.

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 contain 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 of 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, provide the name of the professional who will be verifying your application, and specify their position.

Name of professional

- ☐ 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

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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 sue 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

402-346-8779

FAX 402-342-3395

2222 CUMING STREET

OMAHA, NEBRASKA 68102-4392

Applicant's Name:

1. Please indicate date of your most recent examination of this applicant:

2. Based on your knowledge of the patient's condition, is the information provided on the previous pages a reasonable representation of their condition? ☐ Yes ☐ No

If "no", please explain:

3. Does the applicant have the mental capacity to:

Give addresses and phone numbers?	☐ Yes	☐ No
Recognize a destination or landmark?	☐ Yes	☐ No
Deal with unexpected change(s) in routine?	☐ Yes	☐ No
Ask for, understand and follow directions?	☐ Yes	☐ No
Travel safely / effectively through crowded or complex facilities?	☐ Yes	☐ No

4. Specify which functional limitations are associated with this applicant's condition:

☐ mobility impairment			☐ ***cognitive impairment
☐ compromised endurance	☐ muscular	☐ respiratory	☐ other
☐ visual impairment	☐ total	☐ partial	
☐ hearing impairment	☐ total	☐ partial	

***If this individual has functional limitations due to cognitive impairment, please indicate any of the following issues that are pertinent to this individual:

- ☐ Cannot be left alone to wait for transportation
- ☐ Displays behavior that is unsafe for self or others using public transportation
- ☐ Cannot recognize vehicles that they should board

5. What is the severity of this individual's condition?

☐ Mild ☐ Moderate ☐ Severe ☐ Profound ☐ Chronic

6. What is the expected duration of this individual's condition?

☐ Temporary:	Approximate expected duration until
☐ Long-Term	Potential for functional improvement or periods of
☐ Permanent:	remission No expectation of functional improvement

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?

- ☐ 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	☐ other
☐ walker	☐ power scooter/cart	☐ none
☐ 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)

12. Does the disability/condition prevent the applicant from getting to or from a bus stop?

☐ Yes ☐ No ☐ Sometimes – If "Yes" or "Sometimes", please explain:

13. Does the disability/condition prevent the application from waiting at a bus stop?

☐ Yes ☐ No

How long could the applicant wait, if sitting? minutes.

How long could the applicant wait, if standing? minutes.

How long could the applicant wait, using a mobility device? minutes.

14. Does the disability/condition prevent the applicant from riding a wheelchair accessible bus?

☐ Yes ☐ No ☐ Sometimes – **If "Yes" or "Sometimes", please explain:**

15. Does weather affect the applicant's ability to travel?

☐ Yes ☐ No ☐ Sometimes – **If "Yes" or "Sometimes", please explain:**

16. Does the applicant have medically defined cold sensitivity? ☐ Yes ☐ No

Above or below what temperatures? **If "Yes" please explain:**

17. Does the applicant have medically defined heat sensitivity? ☐ Yes ☐ No

Above or below what temperatures? . **If "Yes" please explain:**

18. **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 mobility assistance, personal care, communication, transportation, sign language interpretation, providing services as a reader, etc., as the client makes their 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:

Hearing 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:

If hearing impaired: what is the degree of discrimination for conventional speech

Without hearing aid(s): [R] [L]

With hearing aid(s): [R] [L]

Cognitively 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:

If cognitively impaired: what are the most recently recorded IQ or Performance Test Scores and date of testing?

What was the onset date of these conditions? (Month/year)

If temporary, what is a reasonably anticipated recovery date for independent travel?

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

Metro Area Transit Office Use Only

Date Certification Received Certification Date:

Type

Conditional Eligibility

Unconditional Eligibility

Temporary Eligibility

Date Certification Denied

Denied Reason:

Appeal Received Date: T.A.C. Board Received Date:

T.A.C. Board Decision: Date: