MetroMobility
a service of the Metropolitan Council

APPLICATION INSTRUCTIONS

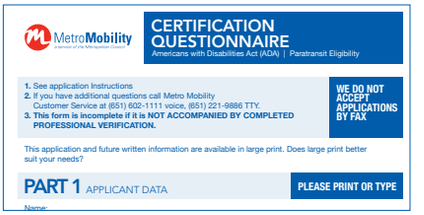
All applicants must submit a complete application which includes **both forms**

(1) The Certification Questionnaire Form

(2) The Professional Verification Form

STEP 1 COMPLETE THE CERTIFICATION QUESTIONNAIRE

The **Certification Questionnaire** should be filled out by the applicant or the applicant's advocate. The form must be filled out in its entirety. It should be signed by the applicant or the applicant's guardian and anyone who assisted the applicant in completing the application.


MetroMobility
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CERTIFICATION QUESTIONNAIRE
Americans with Disabilities Act (ADA) | Paratransit Eligibility

1. See application Instructions
2. If you have additional questions call Metro Mobility Customer Service at (651) 602-1111 voice, (651) 221-9886 TTY.
3. **This form is incomplete if it is NOT ACCOMPANIED BY COMPLETED PROFESSIONAL VERIFICATION.**

WE DO NOT ACCEPT APPLICATIONS BY FAX

This application and future written information are available in large print. Does large print better suit your needs?

PART 1 APPLICANT DATA — PLEASE PRINT OR TYPE

Name:

STEP 2 COMPLETE THE PROFESSIONAL VERIFICATION FORM

The Professional Verification Form must be completed by one of the following professionals who are familiar with the applicant's condition:

- Physicians or Psychiatrists
- Occupational Therapists
- Psychologists
- Physical Therapists
- Licensed Independent Social Workers (LISW, LICSW)
- Recreational Therapists
- Speech/Language Pathologists
- Certified Orientation and Mobility Specialists
- Registered Nurses (RN)
- Doctors of Chiropractic (DC)


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ELIGIBILITY APPLICATION PROFESSIONAL VERIFICATION
Americans with Disabilities Act (ADA)

1. **Complete and sign** the "Authorization to Release Information".
2. **Send** to your designated professional.
3. **Wait** for the professional to return this form to you. Check back with your professional if you don't receive your information.
4. **This form is incomplete if it is NOT ACCOMPANIED BY COMPLETED CERTIFICATION QUESTIONNAIRE.**

WE DO NOT ACCEPT APPLICATIONS BY FAX

SECTION A AUTHORIZATION TO RELEASE INFORMATION — PLEASE PRINT OR TYPE

(WHEN COMPLETE SEND TO THE PROFESSIONAL YOU NAMED)

Applicant's Name: First Middle Initial Last

Birth Date: ____/____/____

Applicant's Address: _____ Apt.#: _____

City: _____ State: _____ Zip Code: _____

Applicant's Telephone Number ( ) _____

I authorize the following professional to release to the MMSC specific information as requested. It is my understanding that the information released will be used solely to determine my ADA paratransit eligibility. I understand that I may revoke this authorization at any time. Unless revoked, this form will allow that professional listed below to release information described for six months after the date appearing below.

Name of Professional: _____ Title: _____

Applicant's Signature: _____ Date: ____/____/____

Guardian's signature required if the applicant is not his/her own guardian.

Guardian's Signature: _____ Date: ____/____/____

To complete the Professional Verification Form

1. Complete and sign the Authorization to Release Information.
2. Send the **Professional Verification** Form to your designated professional.
3. Wait for your professional to return the **Professional Verification** Form to you. Check back with your professional if you have not received the form back in a timely manner.

STEP 3 SUBMIT BOTH FORMS TOGETHER

Submit both the **Certification Questionnaire** and the **Professional Verification** Form in the **same envelope** to

Metro Mobility Service Center
390 N. Robert Street
Saint Paul, MN 55101-1805

WE DO NOT ACCEPT APPLICATIONS BY FAX OR E-MAIL

See additional info on back

STEP 4 IN-PERSON ASSESSMENT

Usually the forms provide Metro Mobility Staff with all of the information needed to make a determination on eligibility. Sometimes however more information is needed. When this happens an applicant may be asked to come in for an **"in-person assessment."**

This assessment may include:

- **A conversation about the applicant's current mobility.** The Metro Mobility evaluator will talk with you about how you currently get around.
- **A pretend bus trip on the computer.** This standardized test is designed to measure a person's cognitive ability to use regular fixed-route transit. *(Functional Assessment of Cognitive Transit Skills or FACTS for short.)*
- **A walk outside or through the skyway.** This will help determine things such as physical ability to get to the regular fixed-route bus as well as memory and landmark recognition.
- **A standard walking and balance test.** This standardized test measures a person's risk of falling. *(Tinetti Gait and Balance Test.)*

PLEASE NOTE THAT APPLICANTS WHO NEED TO COME IN FOR IN-PERSON ASSESSMENTS WILL STILL HAVE THEIR APPLICATIONS PROCESSED WITHIN 21 CALENDAR DAYS.

COMMON ISSUES

In order to make a determination within 21 calendar days the Metro Mobility Service Center must have a complete application. There are several things which may cause an application to be incomplete. By double checking these things PRIOR to submitting your application you may avoid delays in processing.

1. One of the forms is missing. Your application must contain both the Certification Questionnaire and the Professional Verification. Please ensure both are submitted in the same envelope.

2. One of the forms is not signed. Both the Certification Questionnaire and the Professional Verification must be signed. If either the applicant or the professional forgets to sign the form it is considered incomplete.

3. The professional credentials are missing. Professionals must include their titles and credentials when signing the Professional Verification.

Jane Doe X (Incomplete) **Jane Doe M.D. ✓ (Complete)** **Jane Doe R.N. ✓ (Complete)**

AN INCOMPLETE APPLICATION WILL BE RETURNED TO THE APPLICANT ONE (1) TIME. IF IT IS SUBMITTED A SECOND TIME AND IS STILL INCOMPLETE IT WILL BE HELD FOR 60 DAYS BY THE METRO MOBILITY SERVICE CENTER BEFOREIT IS DISCARDED.

APPLICATIONS MUST BE PROCESSED WITHIN 21 CALENDAR DAYS. IF YOUR PROPERLY COMPLETED AND SUBMITTED APPLICATION IS NOT PROCESSED WITHIN 21 DAYS, YOU WILL BE GRANTED PRESUMPTIVE ELIGIBILITY FOR METRO MOBILITY SERVICE UNTIL YOUR APPLICATION IS PROCESSED.

MetroMobility
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CERTIFICATION QUESTIONNAIRE

Americans with Disabilities Act (ADA) | Paratransit Eligibility

1. See application Instructions
2. If you have additional questions call Metro Mobility Customer Service at (651) 602-1111 voice, (651) 221-9886 TTY.
3. **This form is incomplete if it is NOT ACCOMPANIED BY COMPLETED PROFESSIONAL VERIFICATION.**

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This application and future written information are available in large print. Does large print better suit your needs?

PART 1 APPLICANT DATA

PLEASE PRINT OR TYPE

Name: _____
First Middle Initial Last

Street Address: _____ Apt.#:_____

City: _____ Zip Code: _____

Day Telephone: ( ) _____ Evening Telephone: ( ) _____

Email Address: _____

I prefer communication via email: ____Yes ____No

Birth Date:_____/_____/_____

Do you have a Minnesota state ID card or Minnesota driver's license? ☐Yes ☐No

ID # _____ License # _____ Expiration Year: _____

Mailing Address (if different from above)

Street Address: _____ Apt.#: _____

City: _____ Zip Code: _____

Emergency Contact Person

Name: _____
First Middle Initial Last

Day Telephone: ( ) _____ Evening Telephone: ( ) _____

1. Are you able to travel in an automobile? ____Yes ____No

2. If you use a wheelchair or scooter:

Is it more than 30 inches wide? ____Yes ____No

Is it more than 48 inches long? ____Yes ____No

Is the combined weight of device and occupant more than 600 pounds? ____Yes ____No

3. Which of the following assistive devices, if any, do you use? *(Please check all that apply.)*

☐ Cane	☐ Manual Wheelchair	☐ Boarding Chair	☐ Prosthesis
☐ White Cane	☐ Powered Wheelchair	☐ Service Animal	☐ Communication Aid
☐ Walker	☐ Powered Scooter/	☐ Portable Oxygen	☐ Other (please describe):
☐ Crutches	☐ Cart	☐ Transfer Board	_____

If you selected Wheelchair or Scooter, would you prefer/need to use the device while riding in Metro Mobility Vehicles? ____Yes ____No ____Sometimes

4. Does your health condition/disability require you to use Metro Mobility service:

☐Seasonally (Nov. - Apr.)
☐Permanently ☐ Temporarily
☐If temporarily, for how long? ☐ Week(s) ☐Month(s)

5. Does your health condition/disability change from day to day in ways that occasionally disrupts your ability to use regular-route city bus service? ____Yes ____No
If yes, please explain: _____

6. When using Metro Mobility service, does your health condition/disability require you to travel with someone to assist and/or supervise you? ____Yes ____No

PART 2 QUESTIONS ABOUT USING REGULAR-ROUTE PUBLIC TRANSIT

Complete Part 2 even if you are unable to use regular-route city bus service. This information will assist us in determining how your disability/health condition affects your ability to use regular-route city bus service.

7. Do you now independently use regular-route city buses? ____Yes ____No ____Sometimes
If "Yes" or "Sometimes," how many times? ☐per week ☐per month ☐per year

Which of the following best describes how you use regular-route city buses?
☐ To travel to and from one destination only
☐ To travel to and from a few destinations
☐ To travel to and from many different destinations

Explain what prevents you from independently using regular-route city bus.

_____

_____

_____

_____

_____

_____

8. Have you ever had training to use the regular-route city buses? ____Yes ____No

9. Using a mobility aid or on your own, how far are you able to travel without the assistance of another person?

☐3 blocks ☐6 blocks
☐9 blocks or more ☐less than 3 blocks

10. I can wait for a regular-route city bus (check all that apply):

☐Only if there is a bench or shelter
☐Up to 15 minutes ☐More than 15 minutes

11. Please check all the categories below as they relate to your ability to use regular-route city buses:

	I am:	Yes	No	Sometimes
A.	Able to tolerate very hot or very cold weather	☐	☐	☐
B.	Able to recognize destinations, bus stops, or landmarks	☐	☐	☐
C.	Able to tolerate air pollution (smog, fumes, perfume)	☐	☐	☐
D.	Free from night blindness	☐	☐	☐
E.	Able to recognize printed information	☐	☐	☐
F.	Able to hear and process spoken words or auditory information	☐	☐	☐
G.	Able to communicate needs	☐	☐	☐
H.	Able to follow directions	☐	☐	☐
I.	Able to deal with unexpected situations or changes in routine (example: bus detours)	☐	☐	☐
J.	Able to safely and effectively travel through crowded and/or complex facilities	☐	☐	☐
K.	Able to recognize changes in terrain	☐	☐	☐
L.	Able to travel independently along sidewalks and other pedestrian ways	☐	☐	☐
M.	Able to cross streets independently	☐	☐	☐
N.	Able to find the correct bus stop	☐	☐	☐
O.	Able to identify the correct bus	☐	☐	☐
P.	Able to get on and off a bus using the lift if necessary	☐	☐	☐
Q.	Able to deposit fare into the fare box or show bus pass	☐	☐	☐
R.	Able to get to a seat/wheelchair position and remain seated during a bus trip	☐	☐	☐
S.	Familiar with what to do if I miss my bus	☐	☐	☐

If you checked “No” or “Sometimes” to any of the items in question 11, please explain:

More Space Provided On The Next Page

PART 3 APPLICANT SIGNATURE

The information provided on this form is private data and is used to determine ADA paratransit eligibility. The ability to determine your eligibility is based on receiving all of the information requested on this form. All medical, visual or locational information pertaining to application for or users of ADA paratransit service is private. No information related to Metro Mobility can be released to anyone else, unless the applicant or user authorizes the release in writing. If you are determined ADA paratransit eligible, information about your eligibility status will be entered into a database maintained by the Minnesota Department of Public Safety, Driver and Vehicle Services Division. This information could be used by Drivers License Division of the Department of Public Safety to (1) Reexamine your driving ability or, (2) Demand that you surrender your license if a severe disabling condition has developed since the current license was issued.

I certify that all information on this application form is accurate. I understand that misinformation or misrepresentation of facts will be cause for disqualification or rejection of my ADA eligibility. I also understand that additional information relating to my health condition or disability may be required to determine eligibility. This information may be obtained through an in-person assessment or by requesting information from a professional who understands my health condition or disability. Additional information will be required only when the information provided on the application form does not clearly determine ADA paratransit eligibility.

Applicant's Signature: _____ Date:_____/_____/_____

*If the applicant is not his/her own guardian, the following information about the guardian is required:

Guardian's Name: *(please print)* _____
First Middle Initial Last

Day Phone: ( ) _____

Guardian's Signature: _____ Date:_____/_____/_____

*If someone other than the applicant or the applicant's guardian is preparing this form, please provide the following information about the preparer:

Name: *(please print)* _____
First Middle Initial Last

Day Phone: ( ) _____

Preparer's Signature: _____ Date:_____/_____/_____

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ELIGIBILITY APPLICATION PROFESSIONAL VERIFICATION

Americans with Disabilities Act (ADA)

1. **Complete and sign** the "Authorization to Release Information".
2. **Send** to your designated professional.
3. **Wait** for the professional to return this form to you.
   Check back with your professional if you don't receive your information.
4. **This form is incomplete if it is NOT ACCOMPANIED BY COMPLETED CERTIFICATION QUESTIONNAIRE.**

WE DO NOT ACCEPT APPLICATIONS BY FAX

SECTION A AUTHORIZATION TO RELEASE INFORMATION

PLEASE PRINT OR TYPE

(WHEN COMPLETE SEND TO THE PROFESSIONAL YOU NAMED)

Applicant's Name: First _____ Middle Initial _____ Last _____

Birth Date:_____/_____/_____

Applicant's Address: _____ Apt.#:_____

City: _____ State:_____ Zip Code: _____

Applicant's Telephone Number ( ) _____

I authorize the following professional to release to the MMSC specific information as requested. It is my understanding that the information released will be used solely to determine my ADA paratransit eligibility. I understand that I may revoke this authorization at any time. Unless revoked, this form will allow that professional listed below to release information described for six months after the date appearing below.

Name of Professional: _____ Title:_____

Applicant's Signature: _____ Date: _____/_____/_____

Guardian's signature required if the applicant is not his/her own guardian,

Guardian's Signature:_____ Date: _____/_____/_____

SECTION B METRO MOBILITY PROFESSIONAL VERIFICATION FORM

Dear Health Care Professional:
You are being asked to provide information regarding this individual's disability. The Federal Law is very specific about ADA para-transit eligibility. The law restricts eligibility to individuals who,

1. as a result of their disability, cannot board, ride, or disembark from a regular fixed route bus or light rail car or
2. have a specific impairment-related condition which prevents them from getting to or from a bus stop.

PLEASE NOTE: This **does not** include persons who find it **difficult** or **uncomfortable** to get to and from bus stops. *In providing information you should consider only the presence of a disability or health condition and not the applicant's age or economic status. Metro Mobility staff makes the final determination on eligibility status.*

THIS SECTION MUST BE FILLED OUT FOR ALL APPLICANTS

GENERAL INFORMATION

• Describe the diagnosed disability you are currently treating this individual for:_____

_____

• Describe any other health conditions or disabilities with which this individual is diagnosed: _____

_____

• Date of onset ____/____/____

• Date of last visit ____/____/____

• How long have you worked with the individual? Since ____/____/____

• Is disability temporary _____ or permanent _____ ?

If permanent is disability progressive? ____Yes ____No

If temporary please give best estimate of rate of recovery. _____

• Is therapy part of treatment? ____Yes ____No If yes, give brief description_____

_____

• Do temperature extremes affect the individual?

(Ex. Heat index of more than 85 degrees or wind chill less than 10 degrees) ____Yes ____No
If yes, how so? _____

• Please list all medications. _____ _____

_____ _____

_____ _____

• Is this individual compliant with taking medications? ____Yes ____No

• Does the individual currently uses regular route public transportation? ____Yes ____No ____Not Sure

• Is the individual's judgment impaired ____Yes ____No

• Is behavioral inhibition impaired? ____Yes ____No

• Can the individual walk? ____Yes ____No

• Does the individual use a mobility aid? ____Yes ____No Please list _____

_____

• How long has individual been using the device(s)? _____

_____

• How far can the individual travel without the assistance of another person?
☐3 blocks ☐6 blocks ☐9 blocks or more ☐less than 3 blocks

• With treatment/therapy will this distance increase? ____Yes ____No

• Please indicate the expected distance after treatment/therapy:
☐3 blocks ☐6 blocks ☐9 blocks or more ☐less than 3 blocks

• Give best estimate of length of time required to achieve this improvement. _____

_____

PLEASE COMPLETE ONLY THOSE SECTIONS THAT APPLY TO THIS INDIVIDUAL

NEUROLOGICAL IMPAIRMENT/HEAD INJURY

• Does the individual experience seizures? ____Yes ____No Date of last seizure _____/_____/_____

• Please give no. of seizures _____ and frequency _____

• What type(s) of seizures does patient experience _____

• Does individual experience auras? ____Yes ____No

• Is the individual's judgment impaired? ____Yes ____No

• Is behavioral inhibition impaired? ____Yes ____No

• Does judgment and inhibition impairment prevent the individual from independently traveling outside the home or immediate environment? ____Yes ____No

• When traveling independently does the individual have the ability to: *(check all that apply)*

☐Get help if lost ☐Recognize & avoid danger ☐Cross streets safely

☐Follow written directions ☐Communicate needs ☐Process information

☐Understand and follow schedule to get places on time

• Is there history of Brain Injury ____Yes ____No. Date of injury_____/_____/_____

VISUAL IMPAIRMENT

• Please provide visual acuity measurements and visual field readings for both eyes.
OS: _____ **OD:** _____

• Does the individual require any accommodations, adaptations, low vision aids, etc? Please list:

_____

_____

• How does the individual's visual impairment affect their ability to move about in the environment?

_____

_____

• Has the individual received any orientation & mobility (O&M) training? ____Yes ____No

COGNITIVE/MENTAL IMPAIRMENTS

• Does the individual experience any of the following:

☐ Auditory hallucinations ☐ Visual hallucinations ☐ Delusions ☐ Disassociation

• Does this prevent the individual from being oriented to person, place, and time? ____Yes ____No

• Is the individual currently being treated for any of the following:

☐ Anxiety ☐ Depression ☐ Panic attacks ☐ Schizophrenia

☐ Other: _____

• For anxiety panic attacks please indicate on average the frequency and length of panic attacks.

Per day_____ Per week_____ Per month_____ Per year_____

Approx. duration: _____

• What technique(s) and/or skills is the individual utilizing to assist in coping with the above issue(s)?

☐ Visualization ☐ Relaxation techniques ☐ Positive self-talk ☐ Aroma therapy

☐ Other:_____

• Are these techniques effective in reducing symptoms? ____Yes ____No

• Is there a history of Electroconvulsive Therapy (ECT)? ____Yes ____No ____Unknown

Please list IQ score and GAF score if known. IQ = _____ GAF = _____

• Please describe the functional limitations caused by this impairment?

_____

_____

• Is the individual's judgment impaired? ____Yes ____No

• If yes, please describe to what extent or give an example. _____

_____

• Is the individual able to live independently? ____Yes ____No

Additional Comments: _____

_____

PLEASE RETURN FORM TO APPLICANT **PLEASE PRINT so that we may contact you if needed**

Name of Professional: _____ Date: _____/_____/_____

Title: _____

Street Address:_____

City: _____ State: _____ Zip Code: _____

Telephone Number: ( ) _____ Fax: ( ) _____

☆ **Doctor/Health Care Professional Signature:** _____

**Form must be signed with credentials to be valid.*