

Thank you for inquiring about eligibility for MetroAccess ADA Paratransit Service. MetroAccess is for individuals with a disability or disabling health condition that prevents them from independently using the accessible MetroBus and MetroRail service either all of the time, temporarily or under certain circumstances. The Americans with Disabilities Act (ADA) outlines specific criteria to determine eligibility for paratransit services; therefore, an application and in-person eligibility review are required to determine an applicant's individual eligibility.

Enclosed are the ADA Paratransit Application and information on completing the MetroAccess Eligibility Process. If you need any type of alternative format of this application or additional information please contact (512) 389-7501 or eligibility@capmetro.org.

To apply for this service, you and your provider must complete this application. Please read and follow these instructions:

- 1
 - Complete Part A: Applicant Information & Release.
 - Have your licensed/registered healthcare or human services provider complete Part B: Health Care Provider Verification. The applicant MAY NOT complete this section.

Examples of providers that are approved to complete the Part B Provider Verification include: Physician, Physician Assistant, Registered/Licensed Nurse, Nurse Practitioner, Podiatrist, Chiropractor, Optometrist, Licensed Therapist, Licensed Social Worker, Certified O&M Specialist, Licensed Psychologist, Licensed Counselor, and Certified Special Education Teacher. If you have any questions about providers, please call the Eligibility Department at 512-389-7501 for assistance.

- 2
 - Once ALL paperwork is complete, you may either:
 - Mail to Capital Metro at 2910 E 5th Street Austin, TX 78702
 - Fax to (512)-369-7779
 - Email to eligibility@capmetro.org OR call the Eligibility Department at (512) 389-7501 and complete a short prescreen interview to set up your eligibility review.

Please Note: if you have not submitted the original application form to MetroAccess, you must bring the original document to your appointment. Capital Metro offers transportation free of charge to and from the in-person eligibility review.

- 3
 - You will receive your eligibility determination within 21 calendar days from the date all the following are completed:
 - Full application and verification received
 - In-person Eligibility Review (with functional assessment as necessary)
 - Any additional requested information is received by staff

Any applicant who has completed the steps above but has not received an eligibility determination from Capital Metro within 21 days will be entitled to unlimited use of MetroAccess services until you are notified of the eligibility determination.

PREPARING FOR YOUR ELIGIBILITY REVIEW

Please bring the following items:

- The ORIGINAL application and Professional Verification forms (unless you have previously submitted the originals to our office)
- Statement of Visual Acuity if you have a visual impairment
- Photo Identification
- Any additional documentation you wish to have considered in the eligibility determination
- All mobility aids (including service animals) that you typically use in the community
- Any chargers necessary for use of electronic medical or mobility equipment
- Full oxygen tank if you use oxygen for any daily activities
- List of current medications (if you feel they are relevant to your daily functional abilities)

PLEASE NOTE:

- As your eligibility review may take up to 2 hours, you are encouraged to plan accordingly by bringing any necessary medications, water, snacks, or anything else you may need for this length of time away from home.
- You may be required to participate in a functional assessment in the community for us to best determine your functional abilities. This assessment will be conducted outside, so please dress accordingly on the day of your appointment. Please be sure to wear appropriate footwear for traveling outside in the community and bring any necessary protection for weather conditions that are present on the day of your appointment.
- You may bring a guest of your choosing with you for the interview portion of the Eligibility Review. For safety purposes, we ask that your guest(s) remain in the lobby during the functional assessment. Please have adult supervision arranged for any children that may be traveling with you.
- There is no onsite parking at the Eligibility & Mobility Training Center. If you do not wish to use the complimentary MetroAccess transportation for your appointment, there is metered parking in the surrounding area available. Please note it may be limited.

ELIGIBILITY & MOBILITY TRAINING CENTER

Phone: 512-389-7501

Fax: 512-369-7779

Email: eligibility@capmetro.org

Mailing Address: 2910 East 5th St, Austin, TX 78702

Physical Location: 209 W 9th St, Austin, TX 78701

Business Hours: Monday – Friday 8:00 AM – 5:00 PM

ALL ELIGIBILITY REVIEWS ARE BY APPOINTMENT ONLY

**METROACCESS SERVICES ASSESSMENT
INFORMED CONSENT & HEALTH INFORMATION**

I understand that part of the functional assessment occurs indoors and outdoors.

I may be asked to perform several activities:

- Physical tasks such as walking or using mobility aid to travel several city blocks or a distance equal to the average street length within a specific time, going up and down curbs and/or curb cuts, and getting on and off a simulated public transit bus.
- Cognitive tasks such as recognizing bus route numbers, finding the way to a specific place and obtaining public transit information.
- Obtaining a weight and measurement of me with my mobility aid.
- Having a digital photo taken (for the purpose of providing Access services only).

I understand that private health information from the evaluations will be kept confidential. It will be reviewed by Capital Metro staff and those performing the evaluations and used to help determine my eligibility for MetroAccess Services. I have read this form and I understand the evaluation procedures and agree to assume the risks and take responsibility for injury or property damage suffered by me during the evaluations not caused by negligence on the part of MetroAccess.

Signature of Applicant (Guardian if Applicable)

Date

PART A: APPLICANT INFORMATION & RELEASE

Last Name _____ First Name _____ Middle Initial _____

Street Address _____ Apartment # _____ Gate Code _____

City/State/Zip _____ County or City _____

Gender Male Female Date of Birth _____ Email _____Primary phone number () _____ Home Cell WorkSecondary phone number () _____ Home Cell Work

In case of emergency, who should be notified? _____

Relationship _____ Phone () _____

Do you require the use of a mobility device when traveling? Yes NoCheck all that apply: Power Wheelchair or Scooter Manual Wheelchair Support Cane Portable Oxygen Crutches
 Walker White Cane (for visually impaired) Other: _____Do you use a service animal? Yes No SometimesIf yes, please describe the type of animal and what service(s) the animal is trained to perform:

_____**METROACCESS APPLICANT AGREEMENT & AUTHORIZATION**

I agree that if I am certified for MetroAccess, I will pay the exact fare, if required, for each trip. I agree to notify the MetroAccess office of any changes in my status which may affect my eligibility to use the service. I also understand that failure to adhere to the MetroAccess policies and procedures will be grounds for suspension from service.

I understand and agree to hold MetroAccess harmless against all claims or liability for damages to any person, property or personal injury occurring as a result of my failure to equip or maintain the safety of the adaptive equipment or service animal that I require for mobility. I have read and fully understand the conditions for service outlined in the MetroAccess Policies and Procedures and agree to abide by them.

I hereby authorize the release of verification information and any additional information to Capital Metro for the purpose of evaluating my eligibility to participate in the MetroAccess Program. I certify that the information provided in this application is true and correct.

I certify that all information contained in part A of this application was completed by me or my appointed representative and is true.

Signature of Applicant_____
Date



PLEASE NOTE: This form must be filled out in its entirety by the treating professional. Any form with requested information altered or omitted will not be processed and will be returned to the applicant.

PART B: PROVIDER VERIFICATION (Copies, faxes or scans will not be accepted.)

Dear Provider:

Your patient/client has requested eligibility for MetroAccess services and you are being asked to provide information regarding this individual's disability. To qualify for MetroAccess service, the applicant's condition must prevent them from traveling on Capital Metro fixed route service, either all of the time, temporarily or only under certain circumstances. **Disability or age alone and distance to and from a bus stop do not, by themselves, qualify a person for paratransit service.**

For the benefit of the applicant, please answer all applicable questions as fully and accurately as possible. All information will be kept strictly confidential, according to law. In order to best determine this applicant's functional abilities, **we require that you, the healthcare provider, complete and certify all of the following sections.**

▶ Name of Applicant _____ Applicant DOB _____

▶ Written Diagnosis (es) and ICD-10-CM and/or DSM Code(s) _____

▶ When did you begin working with this individual? ____ / ____ / ____ (mm/dd/yyyy)

▶ Does the individual have any pending treatments or procedures? Yes No

If yes, please describe (expected date and procedure): _____

▶ If applicant has a seizure disorder or epilepsy, have they had a seizure within the past 6 months? Yes No N/A

If yes, please specify type of seizure _____ and date of last seizure ____ / ____ / ____

NOTICE REGARDING HYPERTENSION

Eligibility for service is determined by a functional assessment, which is conducted by a licensed therapist at the Eligibility and Mobility Training Center. Applicants may be required to walk/travel distances up to 3/4 mile. In order to ensure the safety of the applicant, a blood pressure (B/P) reading is taken prior to starting the assessment. If the applicant's resting B/P is 180/110 or higher, the assessment will be suspended pending certification by the health care provider that the applicant can complete the assessment. If you are currently treating the applicant for hypertension and certify that he/she is cleared to complete the functional assessment, we may proceed without referring the applicant back to you for evaluation and certification.

▶ Are you currently treating this applicant for hypertension? Yes No

If yes, applicant can complete the assessment if B/P **does not go above** a reading of: ____ / ____

PART B: PROVIDER VERIFICATION (page 2)

▶ Does the applicant have a diagnosed visual impairment? Yes No

If yes, please complete the following information for Visual Acuity and Visual Fields with best correction:

BEST CORRECTED ACUITY: Left Eye _____ Right Eye _____

FIELD RESTRICTION: Left Eye _____ Right Eye _____

▶ Does the applicant require any of the following mobility devices in order to access public transportation? Check all that apply:

- Power Wheelchair or Scooter Manual Wheelchair Support Cane Portable Oxygen Crutches
- Walker White Cane (for visually impaired) Other: _____

▶ In your professional opinion, what other factors related to the applicant’s disability(ies) affect his/her ability to travel independently from one location to another on the accessible Capital Metro fixed-route system?

PROVIDER INFORMATION

Name of Provider (please print) _____

License Number/State Issued _____ Specialization _____

Phone () _____ Fax () _____ Email _____

Street Address & Suite # _____

City/State/Zip _____

I certify that I have read and completed all the information in Part B and that the information provided is correct.

Original Signature of Provider
NOTE: Must be original hand signature, not signature stamp

Date