MetroMobility
a service of the Metropolitan Council

APPLICATION INSTRUCTIONS

All applicants must submit a complete application which includes both:

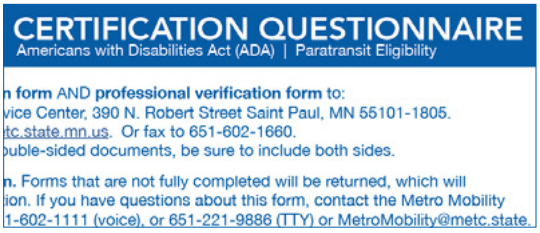
(1) The Certification Questionnaire (blue text form); and

(2) The Professional Verification Form (red text form).

If we do not process your properly completed application within 21 days, you will be eligible for Metro Mobility until we complete the certification process. More information at metromobility.org.

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.


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

n form AND **professional verification form** to:
vice Center, 390 N. Robert Street Saint Paul, MN 55101-1805.
tc.state.mn.us. Or fax to 651-602-1660.
uble-sided documents, be sure to include both sides.

n. Forms that are not fully completed will be returned, which will
ion. If you have questions about this form, contact the Metro Mobility
1-602-1111 (voice), or 651-221-9886 (TTY) or MetroMobility@metc.state.

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:


PROFESSIONAL VERIFICATION FORM
Americans with Disabilities Act (ADA)

horization to Release Information" (Section A).
ND SIGNED by your designated professional.
filled out completely.
n questionnaire and professional verification forms together.
lete or arrive in separate installments will not be processed.

r 390 N. Robert St., Saint Paul, MN 55101-1805.
tc.state.mn.us.

uble-sided documents, be sure to include both sides.

- Physicians or psychiatrists;
- Occupational therapists;
- Psychologists;
- Physical therapists;
- Licensed Independent Social Workers (LISW, LICSW);
- Recreational therapists;
- Speech/language pathologists;
- Certified Orientation and Mobility Specialists (COMS);
- Registered Nurses (RN);
- Doctor of Chiropractic (DC);
- Certified Rehabilitation Counselor (CRC);
- Vocational Rehabilitation Counselor (VRC).

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

Or via fax to 651-602-1660
Or via e-mail to metromobility@metc.state.mn.us
If you are scanning or faxing double-sided documents, please be sure to include both sides.

STEP 4 IN-PERSON ASSESSMENT

Typically, the forms provide Metro Mobility staff with all the information needed to make a determination on eligibility. Sometimes, however, more information is needed. If 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 functional capacity.** The Metro Mobility evaluator will talk with you about how you currently get around.
- **A simulated 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 assessment will have their application processed within 21 calendar days of their completed assessment.

COMMON ISSUES

To make a determination within 21 calendar days, the Metro Mobility Service Center must have a complete application. There are several things that may cause an application to be incomplete. By double checking these things **before** 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.
4. **Partially completed applications.** This information is necessary to process the application. Skipped portions or missing responses to relevant sections, may be returned for completion.

X **(INCOMPLETE)**
Jane Doe

✓ **(COMPLETE)**
Jane Doe M.D.

Due to the volume of applications we receive, Metro Mobility will return incomplete applications to applicants only once with the incomplete section of the form marked.
If an application is submitted a second time, and is still incomplete, it will be held for 60 days by the Metro Mobility Service Center before it is discarded.

Questions? Please call 651-602-1111

Or visit metromobility.org for additional information.

MetroMobility
a service of the Metropolitan Council

CERTIFICATION QUESTIONNAIRE

Americans with Disabilities Act (ADA) | Paratransit Eligibility

Submit completed **certification form** AND **professional verification form** to:
Postal mail: Metro Mobility Service Center, 390 N. Robert Street Saint Paul, MN 55101-1805.
Or e-mail to metromobility@metc.state.mn.us. Or fax to 651-602-1660.
If you are faxing or scanning double-sided documents, be sure to include both sides.

Complete all parts of the form. Forms that are not fully completed will be returned, which will delay your eligibility determination. If you have questions about this form, contact the Metro Mobility Customer Service Center at 651-602-1111 (voice), or 651-221-9886 (TTY) or MetroMobility@metc.state.mn.us (email). This application and future written information are available in large print. If large print better suits your needs, contact the Customer Service Center, and we will provide you with the alternate formatting.

The purpose of this form is to collect current functional capacity information, therefore:

- Your vulnerable adult status, age, driving status, or distance from a regular city bus service are not factors in determining eligibility.
- Your current Metro Mobility status does not impact the application process.

PART 1 APPLICANT DATA

PLEASE PRINT OR TYPE

Metro Mobility ID number (if re-certification): _____

Name: _____
First Middle Initial Last

Birth Date:_____/_____/_____

Street Address:_____Unit or Apt.#:_____

City:_____ State_____ Zip Code:_____

Primary Telephone: ( ) _____ Alternate Telephone: ( ) _____

Mailing Address (if different from above)

Street Address: _____Apt.#:_____

City: _____Zip Code:_____

Emergency Contact Person

Name: _____
First Middle Initial Last

Primary Telephone: ( ) _____ Alternate Telephone: ( )_____

Language Preferences

If you would like an interpreter for any necessary in-person assessment or phone communication, please list your preferred language. _____

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

☐ Cane ☐ Manual Wheelchair ☐ Service Animal ☐ White Cane
☐ Power Wheelchair ☐ Portable Oxygen ☐ Walker ☐ Power Scooter
☐ Transfer Board ☐ Crutches ☐ Boarding Chair ☐ Communication Aid
☐ Other: (Describe) _____

2. If you will use a wheelchair or scooter while riding Metro Mobility:

Is it more than 30 inches wide? ____ Is it more than 48 inches long? ____
Is the combined weight of the device and the passenger more than 600 pounds? _____

3. What type of Metro Mobility service are you applying for?

☐ Standard (Certified for 4 years)
☐ Temporary: How long? (months, weeks) _____

PART 2 QUESTIONS ABOUT USING REGULAR-ROUTE PUBLIC TRANSIT (THE CITY BUS OR TRAIN)

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.

4. Do you now use regular-route city buses independently? ____Yes ____No ____
If "Yes" or "Sometimes," how many times?____ per week ____ per month____ per year

5. If you do use the regular city bus, please choose which best describes you:

☐ To travel to and from one destination only
☐ To travel to and from a few destinations
☐ To travel to and from many different destinations
☐ Not applicable

6. If you do use the regular city bus, please choose which best describes you:

☐ I travel to **familiar destinations** only
☐ I travel to **new destinations** independently
☐ Not applicable

Please explain **how your health condition, diagnosis, or disability** prevent you, or would prevent you, from independently using regular city bus service.

7. Have you ever had training to use the regular city bus service? Yes____ No_____.
If yes, what was the outcome of the training?_____

_____

_____

8. How far can you travel independently, using mobility aids if needed?
Less than a block ____ 1-3 blocks _____4-6 blocks _____7-9 blocks ____ No significant limits_____.
If your ability to travel is limited, what factors limit you?_____

_____

_____

9. How long can you wait for a regular city bus? (Check all that apply)
Up to 15 minutes _____ More than 15 minutes _____ Only if there is a bench or shelter _____
If your ability to wait is limited, what factors limit you?_____

_____

_____

10. Do you have good days or bad days based on your health condition/disability? (i.e. increase or decrease in symptoms) Yes ___ No ___
If yes, please explain:_____

11. Does your health condition/disability require you to travel with someone to assist and/or supervise you? Yes ___No ____
If yes, please explain: _____

12 Have you fallen in the past 12 months? Yes ___No ____

13. Are you afraid of falling? Yes ___No ____

14. Functional Ability

- Complete the following to the best of your ability, even if you do not currently use regular city buses by answering "yes", "no", or "sometimes" to items A-S.
- If you answer "no" or "sometimes" please describe the impact that your *health condition, disability, or diagnosis* has on your answer.
- Vulnerability, limited bus service, limited experience and inability to drive are not factors in determining eligibility.

I am:

A. Able to tolerate all weather and high/lowtemperatures? _____

B. Able to tolerate poor air quality or pollution? _____

C. Able to recognize or recall destinations, bus stops, or landmarks? _____

D. Free from night blindness? _____

_____

E. Able to read and recognize printed information? Reading level? _____

_____

F. Able to hear and process spoken word or auditory information? _____

_____

G. Are you able to communicate verbally and in writing?_____

_____

H. Able to remember and follow directions or instructions?_____

_____

I. Able to problem solve and deal with unexpected situations or changes in routine?_____

_____

J. Able to effectively travel through crowded and/or complex facilities such a grocery store, office building or mall? _____

K. Able to see curbs, drop-offs, or obstacles in your path?_____

L. Able to independently navigate sidewalks and other pedestrian ways? _____

M. Able to cross streets independently_____

N. Able to climb stairs, travel up inclines, down declines, and uneven ground?_____

O. Able to find and recognize the correct bus stop?_____

P. Able to deposit fare in the fare box or tag a bus pass? _____

Q. Able to get to a seat/wheelchair position and remain seated during the trip if a seat or wheelchair location is available?_____

R. Familiar with what to do if I miss my bus? _____

_____

Feel free to attach any additional notes or documents related to how your health condition or disability are impacted by the items listed above.

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 the information requested on this form. All medical or locational information pertaining to application for, or users of ADA paratransit service is private and cannot 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 may be entered into a database maintained by the Minnesota Department of Public Safety, Driver and Vehicle Services Division. This information could be used by the Driver and Vehicle Services 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 their own guardian, the following information about the guardian is required:

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

Primary Phone: ( ) _____Secondary Telephone: ( ) _____

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:

Preparer's Information

Name: *(please print)*_____

Day Phone: ( )_____

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

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PROFESSIONAL VERIFICATION FORM

Americans with Disabilities Act (ADA)

1. Complete and sign the "Authorization to Release Information" (Section A).
2. Have this from completed **AND SIGNED** by your designated professional.
3. Ensure you have both forms filled out completely.
4. Submit both the **certification questionnaire** and professional verification forms together. Applications that are incomplete or arrive in separate installments will not be processed.

Return by postal mail to:

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

Or e-mail to metromobility@metc.state.mn.us.
Or fax to 651-602-1660.
If you are faxing or scanning double-sided documents, be sure to include both sides.

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

Date of Birth:_____/_____/_____

Applicant's Address:_____Unit/Apt.#:_____

City:_____State:_____Zip Code: _____

Applicant's Telephone Number ( ) _____

I hereby authorize (name/credentials of professional) to release to the Metro Mobility Service Center 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 6 months after the date appearing below.

Name of Professional:_____

Title/Credentials:_____Date: _____/_____/_____

Professional signature on last page

Applicant's Signature:_____Date: _____/_____/_____

Guardian's signature is required if the applicant is not their 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 disabilities. The federal law is very specific about ADA paratransit eligibility. The law restricts eligibility to individuals who, as a result of their disability:

1. Cannot board, ride, or disembark from a regular fixed route bus or light rail car.
2. Cannot travel to and from a regular fixed route bus or light rail car.

PLEASE NOTE: In providing information, you should consider only the presence of a disability and not the applicant's age, economic status, or proximity to transit service.

THIS SECTION MUST BE FILLED OUT FOR ALL APPLICANTS

GENERAL INFORMATION

- List the applicant's diagnoses, disabilities, or health conditions (including both those you are treating and those you are aware of but not treating): _____

_____

_____

_____

- Date of onset ____/____/____ Date of last visit ____/____/____
- Is the disability progressive? Yes___ No___
- If the disability is temporary, please give best estimate for time to recover. _____
- Is therapy part of the treatment? Yes____ No___ If yes, give a brief description, and anticipated outcomes. _____

_____

- Please list all medications. _____

_____

_____

- Is the individual compliant and independent with taking medications? Yes____No_____

COMMUNITY / ENVIRONMENT

- As a direct result of a health condition or diagnosis, does temperature or weather affect the individual?

Yes____ No___ If yes, how so? _____

_____

- Does the individual use a mobility aid? Yes____ No____ If yes please list _____
- How long has the individual been using the device? _____
- Does the individual have any physical limitations that impact their ability to travel or navigate their surroundings? Yes ___ No ____If yes, explain: _____

_____

- How far can the individual travel independently with or without a mobility aid or guidance of another person?

Less than a block ____ 1-3 blocks ____4-6 blocks ____7-9 blocks ____ No significant limits ____

COGNITIVE / MENTAL INFORMATION – IF APPLICABLE

- Please list IQ score if known. IQ _____
- Functional age equivalent: ____ yrs_____ mos
- Provide any other scores or results from measurable test (i.e. WAIS, MMSE, independent living skills, etc) _____

_____

- Is the individual able to live independently? Yes ___ No ____

If no, please indicate functional limitations. _____

_____

_____

_____

PSYCHOLOGICAL / BEHAVIORAL INFORMATION – IF APPLICABLE

- Does the individual experience any of the following?

Anxiety _____ Depression _____ Panic attacks _____ Other _____ Auditory hallucinations _____

Visual hallucinations _____Delusions _____ Disassociation _____ Paranoia _____

- If yes, does this prevent the individual from being oriented to person, place, and time? Yes ___ No ____
- Does the client have a history of psychosis and/or mental health related hospitalizations?

  If yes, when? _____
- For anxiety, panic attacks, catatonia / cataplexy, please indicate on average the frequency and length of symptoms. Per day____ Per week____ Per month____ Per year_____ Duration _____
- Is there a history of Electroconvulsive Therapy (ECT)? Yes ___ No ___

SEIZURES – IF APPLICABLE

Has the individual experienced seizures within the last 6 months? Yes ___No _____

Has the individual experienced seizures on more than one occasion? Yes ___No _____

- Date of last seizure ____ Number of seizures ____ Frequency of seizures (i.e weekly, monthly, etc) _____
- What type(s) of seizures does the patient experience? _____
- Does the individual experience auras or any other indications prior to having a seizure? Yes ___No___
- Please list postictal symptoms and recovery time._____

HEAD INJURIES – IF APPLICABLE

Any history of head injury? (stroke, TBI, ABI, multiple concussion, anoxia, etc)? _____If yes,

- Is the individual's judgment or executive function impaired? Yes ____ No _____
- Is behavioral inhibition or self-regulation impaired? Yes ____ No _____
- Is there any cognitive impact? Yes ____ No _____
- Any visual or physical deficits? Yes ____No _____

How do the above impairments prevent the individual from independently traveling outside of their immediate environment? _____

_____

_____

How do the above impairments prevent the individual from independently traveling outside of their immediate environment? _____

_____

_____

VISUAL IMPAIRMENTS – IF APPLICABLE

Is the individual legally blind? Yes ___No _____

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

_____

_____

- Please provide the corrected visual acuity measurements and visual field readings for both eyes (do not include the prescription for corrective lenses).

Acuity- OS/left: _____ OD/right: _____

Visual field- OS/left: _____ OD/right: _____

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

_____

_____

_____

- Has the individual received orientation & mobility (O&M) training? Yes ____ No ____

PLEASE RETURN FORM TO APPLICANT

PLEASE PRINT so that we may contact you if needed

Name of Professional: _____Title or Credentials:_____

Street Address:_____

City: _____ State: _____ Zip Code:_____

Telephone Number: ( ) _____ Fax: ( ) _____

Professional Signature: _____ Date: _____/_____/_____

☆ *THIS FORM MUST BE SIGNED TO BE COMPLETE* _____

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

Questions? Please call 651-602-1111