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.

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)

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
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 ✗ (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 BEFORE IT 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.

Questions? Please call 651-602-1111
PART 1 APPLICANT DATA

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): ________________

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

If you selected Wheelchair or Scooter, would you prefer/need to use the device while riding in Metro Mobility Vehicles? [ ] Yes  [ ] No  [ ] Sometimes

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:

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

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

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
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 or locational information pertaining to application for or users of ADA paratransit service is private. Any other information 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 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.

PART 3 APPLICANT SIGNATURE

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: _____/_____/______
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.**

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**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: _____/_____/_____

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**Metro Mobility**

**a service of the Metropolitan Council**

**ELIGIBILITY APPLICATION**

**PROFESSIONAL VERIFICATION**

**Americans with Disabilities Act (ADA)**

**WE DO NOT ACCEPT APPLICATIONS BY FAX**
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.

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 _____________________________

____________________________________________________________________________________________
**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

Questions? Please call 612-602-1111
• 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

COGNITIVE/MENTAL IMPAIRMENTS

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:__________________________________________________________________

MMSC Staff will make the final determination of the applicant’s eligibility

  Doctor/Health Care Professional Signature: ________________________________________________

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: (              ) __________________