ADA Eligibility Information

Medical/Professional Verification Form

Name:_____ **Return by:**_____

To the Applicant: Sign below to allow the release of information from the professional who will be filling out this form. Once complete, return the form by the date above in the envelope provided or **fax the completed form to 513-531-6960**

I hereby request that information pertaining to my functional limitations be released to Access, for further determination of my ADA paratransit eligibility.

X Signature: _____ Date: _____

To the person filling out the form:

This form must be filled out by a professional who is knowledgeable about the applicant's capabilities and treating the individual for the disability that prevents them from using Metro (i.e. physical disability should be described by a Physician, OT, PT. Etc). Please check the appropriate box for the person completing this form.

☐ Vocational Rehabilitation Counselor	☐ O & M instructor
☐ Licensed Social Worker	☐ Physician
☐ Senior Program Director	☐ Physical Therapist
☐ Respiratory Therapist	☐ Occupational Therapist
☐ Psychologist	☐ Mental Health Counselor
☐ Psychiatrist	☐ Other _____

Under the Americans with Disabilities Act (ADA), if a person has the functional capability to use Metro, the person is not eligible for Access service. Disability alone and distance to and from a bus stop, by itself, do not qualify a person for Access.

Please assist us in our determination process by providing the following additional information about the applicant named above. All information will be kept confidential.

1. How does the person's disability limit their ability to use a lift equipped Metro bus:

_____
_____
_____

2. Is the applicant's disability temporary? ☐ No ☐ Yes ⇒ ☐ 3-6 mo. ☐ 6-9 mo ☐1yr/more

3. Do you think the applicant could use a Metro bus if someone were to teach the applicant how to do so?
   ☐ Yes ☐ No

4. What is your relationship with the applicant: _____

I certify that the information contained in this application is true and correct to the best of my knowledge and ability.

Signature_____ Date: _____
Print Name _____
Professional Title _____
Clinic/Agency _____
Phone _____
Address _____City _____Zip _____

Return to: Metro/Access ADA Eligibility, 1801 Transpark Dr. Cincinnati, OH 45229

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