ADA Transportation Application

Office Use Only

Appointment time _____ Assessment date _____

Pick up time _____ ID# _____

Return time _____ ☐ PCA ☐ Companion

Access to assessment

☐ Yes ☐ No Expiration date _____

Special pick-up instructions _____

All questions must be answered before your application will be considered.

PLEASE PRINT

Applicant ☐ Male ☐ Female

Last Name _____ First _____ Middle ___

Residence Address: Street _____ Apt. # _____

City _____ State _____ Zip _____

Community Neighborhood (Section of Town) _____

Home Phone ( ) _____ Work Phone ( ) _____ Ext. _____
area code area code

TTY ( ) _____ Note: Metro/Access use Ohio Relay Service
area code

Date of Birth _____ Social Security # _____

Email _____

Emergency Contact

Name _____ Relationship _____

Home Phone ( ) _____ Work Phone ( ) _____ Ext. _____ TDD _____
area code area code

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Applicant Information

1. Are you a: ❑ Current Access rider ❑ New applicant ❑ Visitor

2. Living arrangements:
   ❑ Family/Friend ❑ By Yourself ❑ Group Home
   ❑ Supported Living ❑ Nursing Home ❑ Assisted Living

3. Do you need information given to you in any of the following formats?
   ❑ Large Print ❑ Audio Tape ❑ Braille ❑ None
   ❑ Another Language _____

4. What type of impairment prevents you from using Metro buses? Check all that apply:
   ❑ None ❑ Physical ❑ Visual
   ❑ Mental Illness ❑ Brain Injury ❑ Developmental Disability (DD)
   ❑ Other _____
   Briefly explain why this impairment prevents you from using Metro buses:
   (medical documentation can be provided to further explain impairment)

   _____

   _____

   _____

   _____

5. Is your disability or health condition ❑ Permanent ❑ Weather related
   ❑ Temporary; expected to last until_____ ❑ Varies daily

6. Please indicate the **primary** mobility aids you use when traveling in the community:
   ❑ Support Cane ❑ Leg Braces ❑ Picture Board
   ❑ Long White Cane ❑ Crutches ❑ Alphabet Board
   ❑ Service Animal ❑ Walker ❑ Powered Wheelchair
   ❑ Low Vision Aid ❑ Powered Scooter ❑ Manual Wheelchair
   ❑ Hearing Aid ❑ Prosthesis ❑ Oxygen Tank
   ❑ Other _____ ❑ None

7. Do you require a lift to board the bus? ❑ Yes ❑ No

8. Do you require a Personal Care Attendant (PCA) to help you travel? A PCA is a person specifically employed or designated to help with your daily living needs.
   ❑ Never ❑ Sometimes ❑ Always

9. Have you applied for Access before? ❑ Yes ❑ No
   If yes, how has your condition changed:_____

10. Have you ever used Metro buses or public transit buses in other cities?
    ❑ No ❑ Yes, I currently use them
    ❑ Yes, but I can't any longer due to: _____
    _____

11. Check the items listed below that might help you ride Metro buses:
    ❑ Help with trip planning
    ❑ Help communicating
    ❑ Someone to teach me
    ❑ Wheelchair lift on the bus
    ❑ Bus stops closer to my house
    ❑ Other _____
    ❑ None

12. Can you climb three steps with a hand rail, without assistance?
    ❑ Yes ❑ No ❑ Don't know

13. Has anyone ever taught you how to use Metro buses or public buses in another city?
    ❑ No
    ❑ Yes, from a friend/relative
    ❑ Yes, from an agency: (Name) _____

    Did you complete the training? ❑ Yes ❑ No When _____

    Check the skills you were able to learn:
    ❑ To travel to & from bus stops
    ❑ To ride all or some Metro routes
    ❑ To cross streets
    ❑ To ride the routes listed # _____ # _____ # _____
    ❑ To read bus schedules
    ❑ Other _____

14. What is the closest bus route to your home?
    ❑ Rt. # _____ ❑ I don't know

15. Please put a check mark in the boxes for your usual destinations:
    (This information helps Access better plan service for all customers)

	at least 3-5 times/week	once a week	monthly	occasionally
Work				
Medical				
School				
Shopping				
Recreation				
Other				

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Important: Falsification of this application to obtain, aid, or facilitate another in obtaining Access service violates Ohio Revised Code section 2921.13 and United States Code Title 18, section 1001. Penalties include fines of up to $5,000 and imprisonment up to ten years.

Applicant Verification

Application must be signed at the bottom by Applicant to be considered complete.

Part A. Person completing this form if other than Applicant (check one):

❑ I certify that the information in this application is true and correct based upon the information given to me by the applicant.

❑ I certify that the information provided in this application is true and correct based upon my own knowledge of the applicant's health condition or disability or I have legal authority to complete this application.

Exceptions or Additions _____

_____

Print Name _____ Day phone ( ) _____
area code

Address _____ City _____ State ____ Zip Code _____

Signature _____ Date _____

Relationship to Applicant _____

Agency Name _____

Part B. Applicant signature

I understand that the purpose of this application form is to determine if there are times when I cannot use Metro bus service and will require Access service. I understand that the information on this application will be kept confidential and shared only with the professionals involved in evaluating my eligibility. I certify that to the best of my knowledge, the information on this application is true and correct. I understand that providing false or misleading information could result in my eligibility status being terminated.

I give permission for Metro staff to contact the professional who has filled out this application or given supplemental verification of my condition.

Applicant Signature X _____ Date _____