Mobility Center
4600 E. Washington St., Suite 101
Phoenix, AZ 85034
valleymetro.org
602.253.5000

VALLEY METRO

Valley Metro ADA Paratransit application overview and instructions

The Americans with Disabilities Act (ADA) requires that complementary ADA Paratransit Service be provided to qualified persons who are unable to use Valley Metro bus or light rail services due to a disability. ADA regulations state that individuals must apply and be determined ADA eligible in order to be provided complementary Paratransit Services.

Attached is an application for ADA Paratransit Service and a release of information for verifying your disability. **When you have completed the application and signed the release of information form, please mail both documents to the Valley Metro Mobility Center, 4600 E. Washington, St., Suite 101, Phoenix, AZ 85034.**

Once we receive your completed application and signed release of information form, Mobility Center Staff will reach out, via fax, to the professional(s) you provided to verify the disability that is preventing you from using Valley Metro's accessible fixed route and light rail service. If we cannot verify your disability with your professional(s), your application will be considered incomplete and will be mailed back to you after 30 days.

Once your disability has been verified, we will contact you to schedule your in-person assessment. If you do not have transportation to and from our facility, we can provide you with round-trip transportation free of charge.

2100098501

On the day of your evaluation, please bring the following:

- **Proof of identity** – State ID, Driver's license, Birth certificate, etc.
- **Equipment/Mobility aids** – Any necessary equipment that you use in normal travel or would need to use when travelling on transit services (ie. walker, white cane, oxygen tank).
- **Power wheelchair and scooter users** – Please make sure that your battery is fully charged.

Please be advised that you could be asked to travel up to three-quarters of a mile during your evaluation and you should wear comfortable clothing and shoes. Be advised that you could be away from home for up to four hours. Bring a small snack or drink, medications, sufficient oxygen, etc. should you need them while you are away. You may bring someone with you should you need assistance. It is important to bring someone with you if you require assistance in translating English to another language. Please avoid bringing children or additional person(s) who are not needed to assist you.

After your in-person assessment is completed, Valley Metro will notify you within 21 days of your determination status and/or eligibility. If your eligibility is not determined within 21 days, you may be entitled to receive presumptive eligibility and will be allowed to use ADA Paratransit Service until your eligibility determination is complete.

If you have any questions, please call the Valley Metro Mobility Center at 602.716.2100, Eligibility option.

VALLEY METRO ADA PARATRANSIT

ELIGIBILITY APPLICATION

- Please answer all questions thoroughly.
- Incomplete applications will be returned.
- Sign pages 5 and 6.
- For questions, please call 602.716.2100 (Eligibility option).

PERSONAL INFORMATION - Print clearly

Last Name:________________________First Name:______________________

Middle Name:__________________

☐ Female ☐ Male Date of birth (mm/dd/yyyy) ___________

HOME ADDRESS

Street _______________ Apt/Lot # ___ City _________State ___Zip ______

Name of Complex, if applicable: _____________________________________

Cell phone _______________________Secondary phone _______________

TTY / TDD ☐ Yes ☐ No Email _________________

MAILING ADDRESS (if different from above)

Street _________________ Apt/Lot #__ City __________ State ___Zip ____

EMERGENCY CONTACT (To act in the applicants behalf, if neccessary)

Name _________________________________ Day phone _______________

Relationship ____________________

Do you require information in an alternative format? ☐ Yes ☐ No

If yes, please indicate: ☐ Braille ☐ Large print ☐ Other _________

Your primary language: ☐ English ☐ Spanish ☐ Other __________

Last Name:________________________ First Name:________________________

Middle Name:__________________

MOBILITY INFORMATION - Print clearly

1. What is your physical disability, mental disability, or other qualifying condition which limits your ability to travel? (Please identify most limiting conditions.)

   ____

   ____

   ____

2. Is this condition temporary? ☐ No ☐ Yes If yes, for how long? ________

3. Which of the following mobility aids or equipment do you use when you travel outside your home? Check all that apply.

   ☐ Cane ☐ Oxygen tank ☐ Walker
   ☐ Scooter ☐ Power wheelchair ☐ I do not use any
   ☐ Crutches ☐ Service animal ☐ Other (please specify)
   ☐ Manual wheelchair ☐ White cane __________________

3a. If you have a power mobility device and are no longer using it, please explain.

   ____

   ____

   ____

3b. Do you have plans of getting a power mobility device? ☐ Yes ☐ No

   Estimated date you will receive it: ___________

3c. Does the combined weight of your wheelchair/scooter and your own weight exceed 600 pounds?

   ☐ No ☐ Yes____ lbs.

4. How far can you travel on your own or with the use of required mobility aids?
   ☐ Less than 3 blocks ☐ 3 blocks ☐ 1/2 mile ☐ ¾ mile ☐ 1 mile or more

5. Can you stand for 10 minutes while you wait for your ride? ☐ Yes ☐ No

6. Can you sit for 10 minutes while you wait for your ride? ☐ Yes ☐ No

Last Name:________________________ First Name:______________________

Middle Name:__________________

7. Do you currently use the regular bus service or light rail system?
   ☐ Yes
   ☐ No, because:
      ☐ I have never tried.
      ☐ I have difficulty getting on or off the bus.
      ☐ I have difficulty riding specific bus routes.
      ☐ I have difficulty traveling to and from the bus stops.
      ☐ I have difficulty recognizing bus stops.
      ☐ Other (specify)_____________________________________

8. Could you ride the regular bus if there was a bus stop or bus route near your home?
   ☐ Yes, always.
   ☐ Yes, sometimes.
   ☐ No.

9. Which training would help you to learn to ride the regular bus?
   ☐ Getting on or off the bus.
   ☐ Riding specific bus routes.
   ☐ Traveling to and from the bus stops.
   ☐ Using the wheelchair lift, ramp, and kneeling features.
   ☐ Recognizing bus stops.
   ☐ Other (specify) ____

10. Do you need to travel with a Personal Care Attendant (PCA)?

    Please read carefully before answering:

    - A PCA is someone who travels with you to provide any assistance you need. Your PCA rides free and must board and de-board at the same location as you.
    - Valley Metro operators cannot serve as a PCA. Be aware that you will be left alone on the paratransit van while operators are assisting other customers and you will be dropped at your destination whether or not someone is available to meet you. **If you cannot be left alone, you must arrange for your own PCA.**

Last Name:________________________First Name:______________________

Middle Name:__________________

☐ No – you may still have someone travel with you whenever you wish.
☐ Sometimes – you travel with a PCA at your own discretion.
☐ Yes you cannot travel alone or cannot be left alone at a drop off point.

11. Please explain as completely as possible how your disability prevents you from getting on (boarding), riding, or getting off (de-boarding) a regular bus or how it prevents you from getting to the bus line.

____

____

____

____

12. Did you have a recent injury, surgery or have an upcoming procedure scheduled? ☐ Yes ☐ No

- Date of injury/surgery: __________________
- Type of injury/surgery: ____
- Approx. recovery timeframe: _____________ weeks/months

Be sure to identify the Provider treating you for this condition on page 6.

13. Please list the 3 trips you travel most frequently. This information will help us better serve your travel needs by providing travel planning in advance.

Starting Point Address	Ending Point Address	Time per month
Example: 3010 Yorkshire Dr. Phoenix	4600 E. Washington, Phoenix	4

Last Name:_______________________First Name:_____________________

Middle Name:_________________

CERTIFICATION AND AUTHORIZATION

I certify that the information contained in this application is true and correct to the best of my knowledge. I understand that the purpose of this form is to determine if I am eligible to use Valley Metro Paratransit or Dial-a-Ride Services. I understand that Valley Metro or its contracted agents may need to contact me or see me later to get more information. I further understand that I must be truthful in answering the questions on this form. Giving false or misleading information is against the law and could result in denial of Paratransit / Dial-a-Ride eligibility and services. I agree to immediately notify Valley Metro if I no longer need Paratransit / Dial-a-Ride services.

Applicant Signature:__________________________________ Date: _______

Signature: ____ Date: _______

Signature of individual completing form if not applicant.

Please type or print:

If someone other than the person applying for ADA eligibility completed this application, that person must provide the following information:

Last Name: ________________ First Name:___________________________

Relationship to Applicant: _______________ Daytime Phone #:____________

Company Name: ____

Please complete the Release of Information on the next page.

RELEASE OF INFORMATION

Last Name:________________________ First Name:________________________

Middle Name:__________________

Valley Metro will be contacting an industry professional for verification of your disability and how your disability prevents you from using bus or light rail service. Please provide the information requested below for each professional who is most familiar with you.

All information will be confidential and will only be used to determine eligibility for ADA paratransit service. Valley Metro will not release the information to any other person or agency without your permission. This release is valid for 3 months, unless revoked in writing.

I,________________________ authorize the individual(s) listed below, as well as their office staff, to furnish any information regarding my disability and functional capabilities that may help Valley Metro evaluate my application for Paratransit/ Dial-a-Ride services.

Provider Name:______________________ Profession:________________________

Address:____

Phone:________________________ Fax # **(REQUIRED)**:____________________

Please identify and list the professional(s) who are most familiar with you, such as your:

- ☐ Primary care doctor
- ☐ Internal medicine doctor
- ☐ Eye care provider
- ☐ Mental health prescriber
- ☐ Mental health therapist
- ☐ Renal/Nephrologist
- ☐ Neurologist
- ☐ Rheumatologist
- ☐ Pulmonologist
- ☐ Oncologist
- ☐ Special education instructor
- ☐ DDD case manager
- ☐ Voc Rehab case manager
- ☐ Orthopedic provider/therapist
- ☐ Social worker

Applicant Signature:___________________________________ Date:____________

Date of Birth: (mm/dd/yyyy) ___________

Legal Guardian Signature:_________________________ Phone #:_____________

valleymetro.org
602.253.5000
TTY 602.251.2039