MetroWest Regional Transit Authority

To: **Persons applying for ADA complementary paratransit service**

Enclosed, is the application for ADA eligibility (**Part A**) and the health care provider form (**Part B)**.

Part A should be completed by the applicant.

Part B is to be completed by your health care provider.

After both are complete, you or your health care provider should return **Parts A** and **B** to:

MW *RIDE*
37 Waverly Street
Framingham, MA 01702
ATTENTION: ADA Director

The certification process will be finalized within twenty-one (21) working days of MWRTA receipt of the original completed application.

We will contact you by mail, once your application has been reviewed. A letter will be sent stating your eligibility status. If denied, instructions on our appeal process will be included.

***** Please review the application carefully; **any applications missing information will *not* be considered for certification and will be returned to applicant.**

If you have any questions, please call the

MW Call Center at 508-820-4650

The application will be returned if all sections are not completed.

MetroWest Regional Transit Authority

APPLICATION FOR DETERMINATION OF ADA PARATRANSIT ELIGIBILITY

PART A:

To be completed by applicant

The information obtained in this certification process will only be used by the MetroWest Regional Transit Authority for the provision of ADA complementary paratransit service. This information will not be provided to any other person or agency other than for ADA transit purposes.

The certification process will be finalized within twenty-one (21) working days of MWRTA receipt of the original completed application.

Approval of this application is based on whether or not a person can independently navigate on a Fixed Route Bus System.

****Alternate formats will be provided upon request****

Please Print

Name: _____

Address: _____

City: _____ **Zip Code:** _____

Telephone #: H_____ **W**_____ **C**_____

Date of Birth: _____ **Male**_____ **Female** _____

Emergency Contact Information:

Name: _____ **Relationship:** _____

Telephone #: H_____ **W**_____ **C**_____

The application will be returned if all sections are not completed.

Please check if you are a Veteran { }, or an immediate family member of a Veteran { }.

An Immediate Family Member is described as a Spouse, Parent and Grandparents, Children and Grandchildren, brothers and sisters, mother and/or father in law, brother and/or sister in law, daughter and/or son in law. Adopted, half and step members are also included.

1. In brief detail please explain how your disability(s) prevent you from boarding/riding the fixed route bus service: _____

_____

_____

2. Do you use any of the following mobility aids?

(*Please check all that apply***)**

_____ Cane	_____ Manual Wheelchair	_____Other:_____
_____White Cane	_____ Power Wheelchair	_____Service Animal (specify)
_____ Crutches	_____ Scooter/Cart	_____
_____ Walker	_____ Oxygen	_____ None of the above

3. Using a mobility aid, or on your own, how many blocks can you walk on level ground (1 block = 500 ft**)?** _____

4. Does your disability prevent you from getting to or from a bus stop?

☐ **Yes** ☐ **No**

If Yes please explain: _____

_____

_____

The application will be returned if all sections are not completed.

5. Does your disability prevent you from either boarding, riding or exiting a fixed route bus?

☐ **Yes** ☐ **No**

If Yes please explain: _____

_____

_____

6. Can you climb (3-4) three- four 12 inch steps with railings without assistance?

☐ **Yes** ☐ **No**

If No please explain: _____

_____

_____

7. Please explain if your disability is affected by extremes of hot or cold weather:

_____

_____

_____

8. Are there any other health conditions or disabilities which affect your ability to use our fixed route system?

☐ **Yes** ☐ **No**

If Yes, please explain: _____

_____

_____

The application will be returned if all sections are not completed.

9. Is your disability temporary? ☐ **Yes** ☐ **No**

If Yes, please indicate expected duration.
Condition will last until approximately _____ **20**_____

10. Do you require an escort or attendant you when you travel? i.e. Personal Care Attendant (PCA) (*riders must provide their own PCA***)**

☐ **Yes** ☐ **No**

11. Are you able to ask for, understand and follow directions when traveling?

☐ **Yes** ☐ **No**

If No, please explain: _____

_____

_____

The application will be returned if all sections are not completed.

12. In order to allow the MetroWest Regional Transit Authority to properly evaluate your application, it may be necessary to contact your Licensed Health Care Professional. Please complete the following for informational and authorization purposes.

The following, (check one), My Physician { } Licensed Health Care Professional { } Rehabilitation Professional { } is familiar with my disability and is authorized to provide information to the MetroWest Regional Transit Authority,(or its designee), required to complete this certification.

Physician/Licensed Health Care Professional

Name: _____

Address: _____

City: _____ **Zip Code:** _____

Telephone#: H_____ **W**_____**C**_____

13. To the best of my knowledge, I certify that the information contained in this application is true and correct.

(*Knowingly furnishing false or misleading information could result in denial of ADA complementary paratransit services.)*

Applicants
Signature: _____

Note: Transport of all wheelchairs, regardless of size or weight will be allowed, as long as the lift and vehicle can physically accommodate them.

The application will be returned if all sections are not completed.

14. If this application has been completed by someone other than the person applying for certification, that person must complete the following.

Name: _____

Address: _____

City: _____ **Zip Code:** _____

Telephone#: H_____ **W**_____**C**_____

Signature: _____**Date:** _____

End Of Part A

The application will be returned if all sections are not completed.