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

See additional info on back
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

This application and future written information are available in large print. Does large print better suit your needs?
PART 2

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/ Cart ☐ Portable Oxygen ☐ Other (please describe):
☐ Crutches ☐ Transfer Board

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

PART 2 QUESTIONS ABOUT USING REGULAR-ROUTE PUBLIC TRANSIT

Complete Part 2 even if you are unable to use regular-route city bus service. This information will assist us in determining how your disability/health condition affects your ability to use regular-route city bus service.

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 (example: bus detours)</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>J. Able to safely and effectively travel through crowded and/or 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:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
PART 3  APPLICANT SIGNATURE

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.

**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) __________________________________________

<table>
<thead>
<tr>
<th>First</th>
<th>Middle Initial</th>
<th>Last</th>
</tr>
</thead>
</table>

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) __________________________________________

<table>
<thead>
<tr>
<th>First</th>
<th>Middle Initial</th>
<th>Last</th>
</tr>
</thead>
</table>

Day Phone: (   ) __________________________________________

**Preparer’s Signature:** __________________________________________ Date: _____/_____/_____

4
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.**

**SECTION A AUTHORIZATION TO RELEASE INFORMATION**

(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: ____/_____/______
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 ____________________________

____________________________________________________________________________________________
• 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 651-602-1111
• 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: (              ) ____________________