

Metro Mobility Eligibility Application Professional Verification

SECTION A

This portion of your *Americans with Disabilities Act (ADA)* paratransit application requires information from a professional you identify as being familiar with your disability/health condition.

Here's what you need to do:

- 1. Complete and sign** the authorization form (*Section B*).
Keep Section A for your future reference.
- 2. Send** the completed authorization form (*Section B*) and the Professional Verification Form (*Section C*) **to the professional you have identified.**
- 3.** The professional will send Section B and Section C back to you.
- 4.** You need to *return the followings in the enclosed envelope.*
 - **The ADA Paratransit Application/Recertification**
 - **Section B of this form**
 - **Section C of this form**

Mail to: *Metro Mobility Service Center (MMSC),
390 N. Robert Street, St. Paul, MN 55101-1805*

Incomplete applications will be returned to you.

SECTION A KEEP THIS SHEET FOR YOUR REFERENCE



How long does the application process take?

Once all required information is received, you will be notified within 21 days regarding your eligibility status or if you need to participate in an in-person assessment.

There are several things that you can do to help speed up the process. Be sure you answered all questions on the application form, signed the application, and have included the application and Sections B & C.

Applications received that do not include all three (3) sections will be considered incomplete and will be returned to you. **Incomplete applications will be returned one (1) time. If the same incomplete packet is received again by the MMSC it will be discarded and applicants will need to start the process over.**

Who qualifies as a professional?

It is important that you select a professional who is familiar with your disability/health condition and your functional abilities and limitations. Make sure that your professional meets the criteria necessary in helping to determine your eligibility. The MMSC will accept information from one of the following professionals:

- physician or registered nurse
- licensed independent clinical social worker (LICSW)/licensed independent social worker (LISW)
- psychologist/psychiatrist
- occupational or physical therapist
- certified rehabilitation counselor
- certified orientation & mobility specialist
- certified recreational therapist
- speech language pathologist

Why is an Authorization Release form necessary?

An applicant's authorization is required before the professional can release information to the MMSC. The information is deemed private and is only used in assisting us in determining an applicant's ADA Paratransit eligibility.

If you need this form in an alternative format please call a customer service representative at **(651)602-1111, (651)221-9886 TTY.**



Instructions for the **Authorization**

1. **Complete and sign** the "*Authorization to Release Information*" (Section B).
Keep (Section A) for your future reference.
2. **Send** the completed *Authorization Form* (Section B) and the *Metro Mobility Professional Verification Form* (Section C) to your designated professional.
3. **Wait** for the professional to return *Sections B and C* to you. Check back with your professional if you don't receive your information.
4. **Put your application/recertification form and Sections B & C in the same envelope and mail to:** *Metro Mobility Service Center (MMSC), 390 N. Robert Street, St. Paul, MN 55101-1805* for processing.

SECTION B **Authorization to Release Information**

(when complete send to the professional you named)

Applicant's Name: _____

Date of Birth: ____/____/____

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: _____

SECTION C Metro Mobility Professional Verification Form

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 diagnosed disability you are currently treating this individual for: _____

- 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. <6 mos.____ >6mos.____ >1 year____
- Is therapy part of treatment? Yes____ No____ If yes, give brief description _____

- Do temperature extremes affect the individual?
(Ex. Heat index of >85 degrees or wind chill <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 _____

This section must be filled out for all applicants

GENERAL INFORMATION *Cont'd*

- How long has individual been using the device(s)?

- How far can the individual walk? (With mobility aid if applicable)
3 blocks____ 6 blocks____ 9 blocks____ <3 blocks____
- With treatment/therapy will this distance increase? Yes____ No____
- Please indicate the expected distance after treatment/therapy:
3 blocks ____ 6 blocks____ 9 blocks____ <3 blocks____
- Give best estimate of length of time required to achieve this improvement.

Please complete only those sections that apply to this individual

NEUROLOGICAL IMPAIRMENT/HEAD INJURY

- Does the individual experience seizures? Yes____ No____ Date of last seizure ____/____/____
Please give no. of seizures____ and frequency_____
- 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____

VISUAL IMPAIRMENT * Fill in if applicable

- 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____



EMOTIONAL/BEHAVIOR ISSUES

- Does the individual experience any of the following:
auditory hallucinations____ visual hallucinations____ delusions____
- 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____

COGNITIVE/MENTAL IMPAIRMENTS

* Fill in if applicable

- 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. _____

- * Please list IQ score and GAF score if known. IQ = _____ GAF = _____
- 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: _____