



MASS TRANSPORTATION AUTHORITY
1401 S. DORT HWY, * FLINT, MI 48503*PHONE (810) 767-6950

**Americans with Disabilities (ADA)
Eligibility Application**

Please print:

Last Name: _____ First Name: _____ MI. _____

Address _____

City _____ State _____ Zip Code _____

Date of Birth ___/___/___

Daytime Ph# _____ Evening Ph# _____

TTY# for the Deaf and Hearing Impaired _____ (____) _____ - _____

Do you need information in the following alternative formats?

____ Large Print ____ Braille ____ Audio Tape

Does Applicant need a Personal Care Assistant? Yes ___ No ___

Personal Care Assistant's name: _____

Does Applicant have a service animal? Yes ___ No ___

Emergency Contact:

Name _____

Address _____

Daytime phone# _____ Evening _____

Relationship to Applicant: _____

The Americans with Disabilities Act sets criteria that must be met in Order to be determined eligible for certain transportation services. Eligibility is based not only on the existence of the disability, but on how it affects the applicant’s mobility. The following questions are designed to determine a person’s ability to access the fixed route bus system. “Accessing” involves Getting to and from a bus stop, waiting at the stop, getting on and off the bus, and recognizing environment.

Please answer the questions based on your current level of mobility, regardless of how it may change in the future.

- 1. What is the physical, mental or visual conditions(s), which prevents you from using our fixed route bus system?
Please be very detailed in describing your condition. What is your medical diagnosis?**

- 2. Are you legally blind (visual acuity of 20/200 with best correction in the better eye or visual fields no greater than 20 degrees)?**

_____ yes _____ no

- 3. Have you been diagnosed for psychiatric disability?**

_____ yes _____ no

- 4. Does this cause you emotional or psychological disorientation?**

_____ yes _____ no _____ Sometimes

5. Which of the following mobility aids do you use (please check all that apply):

none portable oxygen service animal
 cane walker prosthesis
 manual wheelchair powered wheelchair other _____

Section 37.165 of the ADA Law states that all “common wheelchairs” and users must be transported. A common wheelchair is a wheelchair that does not exceed 30 inches in width and 48 inches in length measured two inches above the ground, and does not weigh more than 600 pounds when occupied.

6. Does the total weight of your wheelchair/scooter and yourself exceed 600 pounds?

Yes No

7. Does your wheelchair/scooter exceed 30” in width or 48 “ in length?

Yes No

8. Is the condition that limits your ability to use fixed route system:

Permanent
 Temporary If so, until what date? _____
 Intermittent If so, please explain: _____

9. Are you able to travel ¼ mile (3 blocks) to/from a bus stop without the assistance of another person?

Yes No

10. Do you need the lift or ramp to get on and off the MTA bus?

Yes No

11. Can you use the above without assistance?

Yes No

12. Can you complete the following without assistance?

Travel through complex/crowded transit stations.

Yes No Sometimes

If no, or sometimes, please explain _____

13. Do you know when to transfer and when to get on/off the bus without assistance?

Yes No Sometimes

If no, or sometimes, please explain _____

14. How long can you wait outside at an MTA bus stop?

less than 30 minutes more than 30 minutes

15. Are you prevented or limited from waiting at an MTA bus stop or getting on/off of a bus by any of the following?

Check all that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> heat | <input type="checkbox"/> humidity | <input type="checkbox"/> lack of bench/shelters |
| <input type="checkbox"/> cold | <input type="checkbox"/> snow/ice | <input type="checkbox"/> steepness/hills |
| <input type="checkbox"/> mobility aids | <input type="checkbox"/> curbs | <input type="checkbox"/> snow |
| <input type="checkbox"/> grass | <input type="checkbox"/> (3) 12" steps | <input type="checkbox"/> standing on a lift w/handrail |

other(explain)_____

16. Do you have a disability that sometimes, or all of the time, prevents you from boarding, riding or exiting from a MTA bus?

Yes No Sometimes

If yes, please explain: _____

In order to allow the MTA to evaluate your request for ADA eligibility certification, it may be necessary to contact a health care or rehabilitation professional for additional information about your disability and ability to use the regular bus service. It is important that, if possible, you identify a professional who is familiar not only with your particular disability, but who also understands your ability or inability to travel the bus system. Please complete and sign the following authorization and **include verification from a medical professional on your particular disability:**

Name of Professional: _____

Address: _____

City/Town: _____ State: _____ Zip Code: _____

Telephone# _____

Please check what type of a health care professional he or she is:

- | | |
|---|--|
| <input type="checkbox"/> rehabilitation specialist | <input type="checkbox"/> occupational therapist |
| <input type="checkbox"/> independent living counselor | <input type="checkbox"/> vocational rehab counselor |
| <input type="checkbox"/> social worker | <input type="checkbox"/> physician or registered nurse |
| <input type="checkbox"/> psychologist | <input type="checkbox"/> mental health counselor |
| <input type="checkbox"/> audiologist | <input type="checkbox"/> speech pathologist |

Any other information not covered in this application you would like the MTA to consider for your ADA eligibility?

I authorize the professional listed on page 5 to release to the MTA information about my disability and its affect on my ability to travel, which may be needed in connection with my request for ADA eligibility certification. It is my understanding that the information released will be used solely to determine my ADA eligibility. I understand that I may revoke this authorization at any time. All information required will be kept confidential.

Applicant's Signature: _____

Date: _____

PERSON COMPLETING FORM IF OTHER THAN APPLICANT

I certify that the information in this application is true and correct based on the information given to me by the applicant, or based on my knowledge of the applicant's health condition or disability.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO APPLICANT: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE# _____