1900 Main
P.O.Box 61429
Houston, TX 77208-1429

Client ID # _____

Date Entered _____

Processed by _____

Application for METROLift Service

Instructions: On pages 1 – 4 of this application, METROLift is asking for information about you and your ability to use METRO bus service. Please take the time to answer ALL questions carefully and completely. We cannot determine your eligibility for METROLift service without this information. A friend, guardian, caregiver, agency service representative or family member may help you complete your portion of the application, pages 1- 4. Accurate information is required about you, your medical impairment, and your functional capacity. Pages 5 - 6 must be completed and certified by a physician/certified health professional who is familiar with your impairment or condition.

If you have questions, please call METROLift Customer Service at 713-225-0119.

Have you ever applied for METROLift? No ☐ Yes ☐

TO BE COMPLETED BY APPLICANT

Name of Applicant Nombre de solicitante — Last/Apellido	First/Nombre	Middle/Inicial	Social Security Number (ONLY last 4 digits) Numero del Seguro Social del Solicitante (Los ultimos 4 numeros) XXX - XX - _____
Address/Street / Dirección/Calle	Apartment Numero de Apatamento	City/Ciudad	Zip Code/Codigo Postal
Date of Birth/Fecha de Nacimiento	Home Phone Number/En Casa Número de Teléfono	Other Phone/Otro Teléfono	
Apartment Complex Name/Nombre de Apartamentos			Gate Code/Codigo de Cochera
Mailing Address/Dirección de Envío If different from home address/Si diferente de domicilio	City/Ciudad	State/Estado	Zip Code/Codigo Postal
Applicant Signature (required) Firma X _____			Date/Fecha _____

Name of Emergency Contact/Contacto de Emergencia _____ Relationship/Relación _____ Emergency Phone/Numero de Emergencia _____

INDIVIDUAL AND MOBILITY INFORMATION

1. Please state your disability(s).

_____
_____
_____

2. What assistive device(s) do you use when traveling? (Please check all that apply.)

☐ Support Cane	☐ Manual wheelchair	☐ Trained service animal
☐ Crutches	☐ Powered wheelchair	☐ Communications device
☐ Walker	☐ Power scooter	☐ “White cane”
☐ Leg brace(s)	☐ Portable oxygen	☐ None

☐ Other (describe) _____

3. What is the nearest street intersection to your home? (Example: Polk & Wayside)

_____

4. Can you walk or use your wheelchair or assistive device(s) from your home to that intersection without assistance? ☐ Yes ☐ No

If “no,” please explain.

_____

5. Can you find your way to a bus stop without getting lost? ☐ Yes ☐ No

If "no," please explain.

_____

6. How long can you stand and wait for a bus?

☐ 15 minutes ☐ 10 minutes ☐ 5 minutes ☐ Less than 5 minutes

7. All buses have a "destination sign" in front, which shows the route name and number.

Can you read a bus destination sign?	Yes ☐	No ☐
Can you ask the driver where the bus is going?	Yes ☐	No ☐
Can you give or write a note to the driver?	Yes ☐	No ☐
Can you understand the driver's answer?	Yes ☐	No ☐

If "no" to any questions, please explain.

_____
_____
_____

8. If you were on the bus, could you pay the fare by putting money in the fare box, or by tapping the METRO Q Card on the Q box? ☐ Yes ☐ No

.

If “no” please explain

_____

9. If you were on the bus, could you recognize the place where you wanted to get off the bus?
Yes ☐ No ☐

If "no," please explain.

_____

10. Please tell us about the times when you can use METRO’s local fixed-route bus service? (Example: if short distance to bus stop; take attendant; need to get somewhere.)

_____
_____
_____

11. Have you ever received " orientation and mobility training "or " travel training?" Yes ☐ No ☐

If " yes," please list any METRO bus routes on which you can travel:

_____
_____
_____

12. Please tell us the reasons you feel you cannot use METRO’s local fixed-route bus service for some or all trips.

_____
_____
_____

13. How do you currently travel (self, family, friends, bus, rail, METROLift, etc.)?

Please explain.

_____

14. Do you require someone to travel with you? Yes ☐ No ☐
If "yes," please explain

_____

15. Can you wait independently alone at your residence and places to which you travel?
Yes ☐ No ☐

If "no," please explain.

_____

AGREEMENT AND AUTHORIZATION:

I state that the information I have provided is true and accurate.

I authorize the release of diagnostic and functional information as requested on pages 5 and 6 to METRO for the sole purpose of making a determination regarding my eligibility for paratransit service (METROLift) and understand that personal and medical information will be kept confidential.

I understand that intentionally providing false or misleading information or refusal to undergo an in-person interview assessment is grounds for denial of METROLift services.

If approved, I agree to follow the rules and guidelines established by METROLift and to promptly inform METROLift of any changes in my residence, phone number and, if applicable, my representative's name and phone number; and any significant change in my condition that would affect my level of mobility.

I understand that failure to follow proper procedures or cooperate with METROLift staff, demonstrating illegal or disruptive behavior or, if my condition at any time poses a direct threat to the health or safety of others, such situations may result in either suspension and/or termination of service.

_____ _____

Applicant’s Signature: **Date:**

If someone other than the applicant is preparing this form, please provide the following information about the preparer:

Name: (please print) _____

Day Phone: _____ Relationship: _____

Preparer’s Signature: _____ Date: _____

Dear Physician or Healthcare Professional:

We need your assistance in determining eligibility for services provided by METROLift to persons with disabilities who are unable to use local bus transportation. We are seeking specific information as to what prevents the person from using METRORail and the METRO bus routes that provide transportation throughout the area. METRO buses are equipped with ramps, lifts, and kneeling features to assist boarding as well as automatic announcements of major stops to help riders know where they are along the route. The Americans with Disabilities Act of 1990, 49 CFR 37.121, Subpart F states– "..each public entity operating a fixed route system shall provide paratransit or other special service to individuals with disabilities that is comparable to the level of service provided to individuals without disabilities who use the fixed route system." "By complementary, DOT means service for individuals with disabilities who cannot use the fixed route bus system." The information requested of you in the following sections will be used to help determine the applicant's METROLift eligibility. It is important that all questions be answered completely and accurately to the best of your knowledge and in accordance with your records. If the information is incomplete or unclear, we may need to contact you for clarification. Thank you for your cooperation.

1. Have you previously seen this patient? ☐ Yes ☐ No

2. Please rate (Excellent / Good / Fair / Poor / None / Don't Know) the applicant in terms of:

	Excellent	Good	Fair	Poor	None	Don't Know
a. Upper body strength						
b. Lower body strength						
c. Coordination						
d. Balance						
e. Self awareness						
f. Independent judgment						
g. Sense of direction						
h. Ability to understand and follow instructions						
i. Verbal communication						
j. Written communication						
k. Stamina and endurance						

3. In your opinion, can the applicant travel independently from his/her house to the sidewalk?

   ☐ Yes ☐ No ☐ Sometimes

   If "no" or "sometimes," please explain. _____

4. Can the applicant walk up and down two steps? ☐ Yes ☐ No ☐ Sometimes

5. Assuming the use of a mobility aid, if applicable, and with no major barriers in his/her path, how far can the applicant independently travel without assistance?

   ☐ less than 1/4 mile ☐ 1/4 mile ☐ 1/2 mile ☐ 3/4 mile ☐ more than 3/4 mile

6. Does the applicant's disability require him/her to travel with another person who provides personal assistance? ☐ Yes ☐ No ☐ Sometimes

7. Please provide medical diagnoses in layman's terms to describe the applicant's primary impairments or disabling conditions. _____

_____

_____

8. We are seeking specific information as to what prevents your patient from accessing the local bus and rail system. _____

_____

_____

9. Is the condition ☐ Permanent or ☐ Temporary (months) _____

10. If visually impaired, what is the applicant's best corrected acuity?
(Snellen)? (R) _____ (L) _____
Field Restriction: (R) _____ (L) _____ Date of Testing: _____

11. If cognitively impaired, what is the applicant's cognitive age, and IQ level?

_____

12. Is the applicant a wheelchair user? ☐ Yes ☐ No If yes, how often _____

13. Does the applicant use other mobility aids? ☐ Yes ☐ No If yes, please describe.

_____

_____

PHYSICIAN OR HEALTH CARE PROFESSIONAL'S CERTIFICATION :

I certify that the information I have provided herein is a fair representation of this applicant's medical impairment or condition and is accurate to the best of my knowledge. I understand that the information provided herein will be used for the sole purpose of determining the applicant's eligibility for paratransit services. I also agree that METROLift may contact me for clarification of any information I have provided and that I will reply in good faith.

Physician's/Health Professional's Full Name _____

Institution/Facility/Agency Name _____

Street Address _____ Suite # _____

City _____ State _____ Zip Code _____

Medical/Social Worker's License Number _____ Telephone # _____ Fax # _____

Physician's/Health Professional's Signature _____ Date _____

***Note: Additional signature of physician/healthcare professional on his/her letterhead or prescription verifying completion of application is required.