Dear Applicant:

We appreciate your interest in Rock Region METRO's Links Paratransit Service. METRO links is a curb-to-curb demand response service provided to disabled citizens. The enclosed application will determine your eligibility to use METRO links service.

METRO Links is an ADA paratransit service, required by federal law to provide for disabled residents. METRO links is an origin to destination, shared-ride service that complements METRO’s fixed-route bus services. The service is designed to meet the requirements of the Americans with Disabilities Acts (ADA).

The information obtained in this Americans with Disabilities Acts (ADA) certification process will only be used by Rock Region METRO for the provision of transportation services. This information is kept confidential.

The application must be filled out completely and legibly. The enclosed Physician’s Verification of Disability Form must be completed by a doctor, licensed health care provider, licensed rehab/social worker or Orientation Mobility Specialist familiar with your disability.

After METRO Links receives your completed application, you may be contacted to schedule an in-person interview to aid in the determination of your eligibility. Upon request, transportation will be provided to you free of charge both to and from the interview site.

If you require any assistance in completing this application, you may call our office at 501-375-9607. You will receive a determination letter within 21 days of submission.

Again, we thank you for your interest in METRO Links Paratransit Service.
CERTIFICATION OF ELIGIBILITY

Return completed form to:

Rock Region METRO
Links Paratransit Application
901 Maple Street
North Little Rock, AR 72114

PART I – General Information to be completed by applicant. Application must be filled out completely and legibly. (Please Print or Type)

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Email

Date of Birth

In what format would you prefer material on Links service?

☐ Braille ☐ Audio Tape ☐ Large Print ☐ Regular Print

If this is a gated community, please provide gate code: _____________________________

In Case of Emergency Notify:

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<th>Name</th>
<th>Relationship</th>
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OFFICE USE ONLY

Determination:

☐ ADA Unconditional Eligible
☐ ADA Conditional Eligible
☐ Not Eligible

Expiration Date:

☐ 3-years ☐ Other __________

PCA: ☐ YES ☐ NO

Approved By:

Date of Approval:
PART II – Information on disability and mobility equipment

How does your disability prevent you from using METRO’s fixed route bus service?
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Is your disability permanent?  ☐Yes  ☐No
If not, expected duration of your disability?  ____/____/____

Have you ever had a seizure?  ☐Yes  ☐No
If yes, what type? _____________________________ How often? __________________

Are seizures controlled with medication?  ☐Yes  ☐No

Do you use any of the following mobility aids? (Check all that apply)
☐Manual Wheelchair  ☐Walker  ☐Service Animal
☐Powered Wheelchair  ☐Support Cane  ☐Portable Oxygen
☐Powered Scooter  ☐White Cane  ☐Crutches
☐Prosthesis  ☐Braces  ☐Other ____________________________

PART III – Questions on using METRO’s fixed route bus service

1. Have you ever used METRO’s fixed route bus service?  ☐Yes  ☐No

2. Are you able to travel to the nearest bus stop?  ☐Yes  ☐No
   If no, please explain:
   __________________________________________________________________________

3. Are you able to handle money?  ☐Yes  ☐No
   If no, please explain:
   __________________________________________________________________________

4. Are you able to use railings and handles?  ☐Yes  ☐No
   If no, please explain:
   __________________________________________________________________________

5. Are you able to keep balance while seated on a moving bus?  ☐Yes  ☐No
   If no, please explain:
   __________________________________________________________________________
6. Are you able to understand bus schedules?  Yes ❑ No ❑
Understand and follow directions?  Yes ❑ No ❑
Process information to ride Fixed Route?  Yes ❑ No ❑

7. Are you prevented from traveling to or from a bus stop boarding location for one or more of the following reasons?
❑ Inability to negotiate hilly terrain
❑ Extreme sensitivity to climatic conditions
❑ Allergic/Environmental sensitivities
❑ Hyper-fatigue, frailty
❑ Night Blindness
❑ Inability to cross busy intersections
❑ Inability to climb three 10-inch steps
❑ Bus stop too far away

8. Are you able to perform the following functions without supervision?
a) Find your way between familiar locations?
❑ Yes ❑ No ❑ Yes, with training

b) Signal the bus driver to get off at a familiar stop and get off the bus there?
❑ Yes ❑ No ❑ Yes, with training

c) At a bus stop served by more than one bus route, can you distinguish the correct bus to board and indicate your intention to board?
❑ Yes ❑ No ❑ Yes, with training

9. Are you able to perform the following functions without the assistance of another person?
❑ Travel 200 feet (the length of a city block)
❑ Travel $\frac{1}{4}$ mile (the length of three city blocks)

10. Is your ability to get from place to place affected by:
❑ Terrain, such as steep hills, no sidewalks/crosswalks, or other conditions
❑ Rain, snow, ice
❑ Extreme temperatures of heat or very cold

11. Are you able to wait outside for 10 minutes?
❑ Yes ❑ No ❑

12. Do you have trouble standing for more than 15 minutes?
❑ Yes ❑ No ❑
13. Are you able to cross the street of a busy intersection by yourself?  
   ❑ Yes   ❑ No

14. If travel training were available, would you be interested in participating?  
   ❑ Yes   ❑ No

15. Please read the following statements and check those which best describe what you believe is your ability to use a METRO bus without assistance. You may select more than one.
   ❑ I can use the METRO bus for some trips, but not at other times because there are barriers that prevent me from using the system.
   ❑ I use the METRO bus service frequently.
   ❑ I have difficulty understanding and remembering all of the things that I would have to do to find my way to and from the bus.
   ❑ I believe I could learn to ride the bus, if someone taught me.
   ❑ I have a visual disability, which prevents me from getting to and from the bus, even with training.
   ❑ The severity of my disability can change from day to day. I can ride the bus only when I am feeling well.
   ❑ I can never use the bus by myself.
   ❑ I can get to and from the bus if the distance is not too great, and the route is barrier-free.
   ❑ I am not able to use the METRO bus for other reasons. (Please explain):

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________
16. List three of your most frequent destinations, and how you get there?

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<thead>
<tr>
<th>Destination</th>
<th>Frequency of Travel</th>
<th>How do you get there now?</th>
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PART IV – Please initial all of the following statements indicating you have read and understand each statement.

I understand my rights and responsibilities for METRO Links service and they are:

1. METRO Links service is public transportation and I will be sharing rides with other passengers ................................................................. ______

2. METRO Links does not provide emergency service ............................ ______

3. I must show my METRO Links ID and pay the fare each time I ride ................................................................. ______

4. Three “No Shows” in 30 days could result in suspension of service ______

5. I must be present and ready to board the vehicle within my 30 minute window pick-up time ............................................................. ______

6. I am only allowed to carry three (3) grocery bags, or similar sized packages on board ................................................................. ______

7. Wheelchair lifts can accommodate up to 600 lbs, and 30 inches in width. I understand the combined weight of me, my wheelchair, and accessories must weigh less than 600 lbs. I also understand the width of my wheelchair cannot exceed 30 inches .............................................. ______

8. Links reserves the right to require a Personal Care Attendant (PCA) at the time of pick-up. If I am required to have a PCA at the time of pickup, and I do not have one, I will be unable to ride .......................... ______
I certify the information provided in this application is accurate. I understand that false information may result in the denial or termination of METRO Links service. I further understand that all information will be kept confidential, and only the information required to provide the services I request will be disclosed to those who perform those services.

________________________________________
Applicant’s Signature                                      Date

**If someone else is completing this application or has assisted the applicant, that person must complete the following:

________________________________________
Name                                      Relationship

________________________________________
Signature                                      Date

________________________________________
Home Phone                                      Work Phone                                      Cell Phone
Date ______________

Patient Name __________________________

DOB ________________________________

The person named above is ☐ currently being treated or ☐ was formerly treated by me. The person has informed me of his/her intent to apply for Rock Region METRO (METRO) Links service. The information provided in this form is intended to verify any medical/health conditions that prevent the applicant from using METRO’s fixed route bus service.

Please Check One: __ ___ Physician

___ Licensed HealthCareProvider

___ Licensed Rehab/Social Worker

___ Orientation Mobility Specialist

Medical diagnosis and explanation of condition causing disability.

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Disability Status (Select One):
☐ Patient will be temporarily disabled for _______ months.
☐ Patient is considered permanently disabled.

Does the disability prevent the applicant from utilizing the METRO fixed route services (regular bus service)? If yes, please describe in detail.

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

***Please Note***
This form must be filled out in its entirety. Incomplete forms will not be processed and will be returned to the patient.
Can the applicant walk or wheel \( \frac{1}{4} \) mile (3 blocks) without the assistance of another person?

❑ Yes  ❑ No

Can the applicant climb three 10-inch steps with assistance?

❑ Yes  ❑ No

Can the applicant wait outside without support for 15 minutes?

❑ Yes  ❑ No

Is the applicant on dialysis?

❑ Yes  ❑ No

Does the applicant have a hearing impairment?

❑ Yes  ❑ No

Is the applicant able to recognize a destination or landmark?

❑ Yes  ❑ No

Is the applicant able to give addresses and phone numbers upon request?

❑ Yes  ❑ No

Is the applicant able to deal with unexpected situations or unexpected changes in routine?

❑ Yes  ❑ No

Is the applicant able to ask for, understand, and follow directions?

❑ Yes  ❑ No

Is the applicant able to safely and effectively travel alone through crowded and/or complex facilities?

❑ Yes  ❑ No

Does the applicant require a personal care attendant?

❑ Yes  ❑ No

Based upon my professional knowledge of the applicant, I certify that the preceding information is true and correct.

__________________________________________________________________________________

Name (Please Print)  Office Phone Number

__________________________________________________________________________________

Office Street Address  City  State  Zip Code

__________________________________________________________________________________

State License Number (Complete if Applicable - MUST BE CURRENT)

Signature: _______________________________  Date: ______________