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) 375-6717. You will receive a determination letter within 21 days of submission.

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

901 MAPLE, NORTH LITTLE ROCK, AR 72114
(501) 375-6717 • FAX (501) 476-3759

CERTIFICATION OF ELIGIBILITY

RETURN COMPLETED FORM TO:
Rock Region METRO
Links Paratransit Application
901 Maple Street
North Little Rock, AR 72114

OFFICE USE ONLY

Determination:
Links
❑ ADA Unconditional Eligible
❑ ADA Conditional Eligible ❑ Not Eligible
Expiration Date: ❑ 3-years ❑ Other _____
PCA: ❑ Yes ❑ No
Approved By: _____
Date of Approval: _____

PART I: GENERAL INFORMATION

To be completed by applicant. Application must be filled out completely and legibly. **(Please Print or TYPE)**

LAST NAME FIRST NAME MIDDLE

STREET ADDRESS

APT. # APARTMENT COMPLEX NAME (IF APPLICABLE)

CITY STATE ZIP CODE

HOME PHONE WORK PHONE CELL PHONE

EMAIL

DATE OF BIRTH ❑ MALE ❑ FEMALE

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:

_____

NAME RELATIONSHIP

_____

HOME PHONE OR CELL PHONE WORK PHONE

_____

ADDRESS CITY STATE ZIP CODE

PART II: INFORMATION ON DISABILITY AND MOBILITY EQUIPMENT

Please list all of your disabilities and diagnoses, and explain how they prevent you from using METRO's fixed route bus service (regular city bus).

_____

_____

_____

_____

Do you use any of the following mobility aids? (Check all that apply)

❑ Manual Wheelchair
❑ Powered Wheelchair
❑ Powered Scooter
❑ Prosthesis
❑ Walker
❑ Support Cane
❑ White Cane
❑ Braces
❑ Service Animal
❑ Portable Oxygen
❑ Crutches
❑ Other _____

PART III: QUESTIONS ON USING METRO'S FIXED ROUTE BUS SERVICE

If you use a wheelchair or scooter, does your residence have a wheelchair ramp? ❑ Yes ❑ No

Are you able to travel to the nearest bus stop? ❑ Yes ❑ No

If necessary, can you transfer yourself from a wheelchair to a passenger car: ❑ Yes ❑ No

Please explain how your disability affects your everyday functioning level:

_____

_____

_____

_____

Please explain why you feel you are unable to use the regular city bus? (Please be detailed.)

_____

_____

_____

_____

Have you ridden the regular city bus in the past? ❑ Yes ❑ No

Do you understand the regular city bus schedules? ❑ Yes ❑ No

Have you ever had training to use the regular city bus? ❑ Yes ❑ No

Would you like to receive training to use the regular city bus? ❑ Yes ❑ No

Please explain why you are unable to travel to or from the regular city bus stop?

_____

_____

_____

Are you able to move independently in the immediate vicinity of your home? ❑ Yes ❑ No

Are you able to independently navigate shopping areas? ❑ Yes ❑ No

Are you able to monitor health concerns independently? ❑ Yes ❑ No

Are you able to groom yourself independently? ❑ Yes ❑ No

Are you able to tell time independently? ❑ Yes ❑No

Are you able to keep a schedule independently? ❑ Yes ❑No

Are you able to identify coins independently? ❑ Yes ❑ No

Are you able to identify bills independently? ❑ Yes ❑ No

Are you able to make change independently? ❑ Yes ❑ No

Are you able to articulate your needs independently? ❑ Yes ❑ No

Are you able to plan and initiate plans independently? ❑ Yes ❑ No

Are you able to handle money? ❑ Yes ❑ No

Are you able to use railings or handles? ❑ Yes ❑ No

Are you able to travel one city block? ❑ Yes ❑ No

Are you able to travel three city blocks? ❑ Yes ❑ No

Is your ability to get from place to place affected by:

❑ Terrain ❑ Weather ❑ Temperature

❑ Distance ❑ Night or Day ❑ Environmental Problems

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

Please initial here showing that you have received a copy of the client handbook and that you will read it before your first trip. _____

METRO LINKS PARATRANSIT SERVICE PHYSICIAN VERIFICATION OF DISABILITY FORM

Date: _____

Patient Name: _____

DOB: _____

*****PLEASE NOTE*****

This form must be filled out in its entirety. Incomplete forms will not be processed and will be returned to the patient.

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:

❑ Physican ❑ Licensed Health Care Provider

❑ Licensed Rehab/Social Worker ❑ Orientation Mobility Specialist

Please Check All That Apply:

❑ Mental Disability ❑ Physical Disability ❑ Learning Disability

❑ Developmental Disability ❑ Visual Disability ❑ Hearing Disability

Primary Disability: _____

Please Circle One: Mild Moderate Severe

Please Circle One: Temporary Disability Permanent Disability

Secondary Disabilities (Please Specify Temporary or Permanent Disability):

_____

_____

If vision impaired, what is Best Corrected Visual Acuity? (SNELLEN)

Right Eye _____ Left Eye _____

Field Restriction: Right Eye_____ Left Eye _____

List Functional Limitations Related to Mobility
(Please be as specific as possible.):

_____

_____

_____

List Functional Limitations Related to Orientation
(Please be as specific as possible.):

_____

_____

_____

List All Other Functional Limitations (Please be as specific as possible.):

_____

_____

_____

NAME OFFICE PHONE

ADDRESS

LICENSE NUMBER DATE OF EXPIRATION

*****PLEASE NOTE*****

This form must be filled out in its entirety. Incomplete forms will not be processed and will be returned to the patient.

Rock Region METRO

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ , with birthdate of _____,

hereby authorize _____(physician, hospital, clinic, agency, or school), its director, designee, or records department to release information contained in my records to the individual or organization listed below:

1. **Name of person/organization to whom this disclosure is made:**
   Attention: METRO Links Paratransit
   C/O Tonia Wright, Eligibility Specialist
   901 Maple St.
   North Little Rock, AR 72114

2. **Specific type of information to be disclosed:**
   ❑ Medical, includes visual ❑ Psychological ❑ Medication

   For the purposes of:
   ❑ Establish Eligibility for services
   ❑ Help to determine functional limitations

3. **Expiration:**
   This release may be revoked at any time and shall be valid no longer than is reasonably necessary to accomplish the necessary purpose for which it is given, not to exceed 12 months from the date this release form was signed.

_____

Client, Parent, Guardian or Representative Signature Date

_____

Witness Signature if required Date