Application for MTA Mobility

If you need help understanding this information or assistance in completing or understanding Mobility forms or policies, wish to request a reasonable accommodation or modification, or need a copy of this document in an alternative format, please contact Mobility Information at 410-764-8181 or MD Relay 711. You may also contact the Office of Equal Opportunity Compliance Programs at 410-764-8507 or 410-767-3944.

MTA Mobility
Is provided in accordance with the Americans with Disabilities Act (ADA). The ADA requires transit systems that operate fixed route buses/trains to offer complementary paratransit service to people with disabilities who cannot use the fixed route buses/trains for some or all of their trips. MTA Mobility is an origin-to-destination, shared ride, advanced reservation public transit system that is comparable to MTA’s fixed route system in terms of service area and service characteristics.

The MTA Mobility eligibility process looks at each individual’s functional abilities and their ability to utilize MTA’s buses and trains to determine level of eligibility for the program.

The MTA Mobility application process consists of a completed application, completed Healthcare Professional Verification, an interview, and if needed, a functional assessment.

Application Process
1. Complete Part A of the application
2. Have a Healthcare Professional, who can speak to your disability or health condition, complete Part B
   a. Ensure your Healthcare Professional has fully completed Part B, including original signature, license number, and ICD code(s)
3. Once Part A and Part B are completed, call MTA Mobility at 410-764-8181, option 6, Monday - Friday between 8:30 a.m. and 4:00 p.m. to schedule your interview appointment (TDD at Maryland Relay Service at 711)
4. Please bring the following to your interview appointment:
   a. Completed application (Part A and Part B) – DO NOT MAIL YOUR COMPLETED APPLICATION TO THE CERTIFICATION OFFICE
   b. Approved identification
   c. Mobility device that you use in the community
Please note: Applicant interview must take place within 60 days of the completion of Part B.

In order to better serve applicants, MTA Mobility will consider additional forms of identification in lieu of a government approved photo identification if you do not have government approved identification available. MTA Mobility will consider alternative form(s) of identification on a case-by-case basis. If you are unsure about appropriate identification, you may call 410-764-8181, option 6.

MTA has up to 21 days to make a determination. You will receive an eligibility determination letter in the mail that outlines the determination. If your determination is not made within 21 days, you will qualify for Mobility services until such time as an eligibility decision is made. You may contact the reservation center at 410-764-8181, option 1 to schedule a ride until a determination is made.

You have the right to appeal the determination if you do not agree. Information on how to request an appeal will be included with the eligibility determination letter.

**Original Signatures Required**
Part A: Applicant Information *(please print)*

This section to be completed by the applicant, the applicant’s caregiver, or another individual familiar with the applicant’s disability. Please attach supplemental documentation if additional space is required to thoroughly answer all questions.

☐ New Application  ☐ Recertification  If Recertification, Mobility #: __________________________

Demographic Information

Last Name: ___________________________ First Name: ___________________________ MI: ________

Street Address: ___________________________ Apt #: ___________________________

City: ___________________________ State: ___________________________ Zip Code: ___________________________

Mailing Address: ___________________________ Apt #: ___________________________

City: ___________________________ State: ___________________________ Zip Code: ___________________________

Home Phone Number: ___________________________ Cell Phone Number: ___________________________

Date of Birth: ___________________________ Email Address: ___________________________

Emergency Contact Information

Last Name: ___________________________ First Name: ___________________________

Phone Number: ___________________________ Relationship: ___________________________

Transit Usage

1. Have you used MTA buses and trains? ☐ Yes ☐ No ☐ Sometimes

2. Are you able to reach the MTA bus/train stop/station nearest your home? ☐ Yes ☐ No ☐ Sometimes

*If you answered no or sometimes, please explain:* ___________________________

3. What best describes your ability to use MTA’s fixed route service?

☐ I can use the MTA buses and trains for most trips

☐ I can use the MTA buses and trains, but it would be difficult

☐ I can use the MTA buses and trains, but only for specific trips or destinations

☐ I have never tried to use the MTA buses and trains

☐ I cannot use the MTA buses and trains without a personal care attendant

☐ I cannot use the MTA buses and trains at all because: ___________________________
Disability/Health Condition Information

1. What is the primary disability or health condition that prevents you from being able to use MTA’s buses and trains? Please be specific.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Date of diagnosis or onset: ___________________________________________________________________

2. Do you have other disabilities or health conditions that limit your ability to use MTA’s buses and trains? □ Yes □ No

If yes, please explain: ___________________________________________________________________

3. Do the effects of your disability or health condition vary from day to day? □ Yes □ No

If yes, please explain: ___________________________________________________________________

4. Is your disability or health condition: □ Permanent □ Temporary

If temporary, please explain: ___________________________________________________________________

Mobility Aids

1. Check any and all mobility equipment that you expect to use while traveling:

□ Cane □ Braces □ Crutches □ Walker
□ White Cane □ Manual Wheelchair □ Motorized Wheelchair □ Service Animal
□ Scooter □ Respirator/Oxygen □ Other:

2. If you use a wheelchair or scooter, what is the width and length?

Width: _________ inches  Length: _________ inches

3. Do you require a personal care attendant (PCA) with you to provide assistance during travel or at your destination? □ Always □ Sometimes □ Never

If always or sometimes, how does a PCA assist you?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
**Functional Skills**

The following questions will give us more information about your functional abilities. Please select Always (A), Sometimes (S), or Never (N) in response to the following questions.

Without the help of someone else, can you:

1. Ask for and understand written or spoken instructions?  
   If Sometimes or Never, please explain: [ ] A [ ] S [ ] N

2. Cross the street?  
   If Sometimes or Never, please explain: [ ] A [ ] S [ ] N

3. Stand for 20 minutes if there is no place to sit?  
   If Sometimes or Never, please explain: [ ] A [ ] S [ ] N

4. Step on and off a sidewalk from a curb?  
   If Sometimes or Never, please explain: [ ] A [ ] S [ ] N

5. Walk on uneven surfaces?  
   If Never, please explain: [ ] A [ ] S [ ] N

6. Stand on a moving bus or train if there is a handrail?  
   If Never, please explain: [ ] A [ ] S [ ] N

7. Transfer from one bus or train to another?  
   If Never, please explain: [ ] A [ ] S [ ] N

8. What is the farthest that you can travel outdoors (using your mobility aid if you use one) without the aid of another person?  
   [ ] < 1 block [ ] 1-4 blocks [ ] > 4 blocks

Please provide any other information about your disability or health condition that would help us better understand your travel abilities: ________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

**Travel Training**

1. Have you ever had travel training to learn how to travel around the community or how to use MTA buses and trains?  
   [ ] Yes [ ] No

2. Would you like information about travel training to use MTA’s bus/train service?  
   [ ] Yes [ ] No
Voter Registration

1. Would you like to register to vote? □ Yes □ No

*If yes, MTA Mobility will provide assistance to you when you arrive in person for your eligibility appointment*

Certification

I understand that the purpose of this application is to determine if there are times when I cannot use MTA Fixed Route buses, subway, and light rail and I will require paratransit services. I understand that the information on this application will be kept confidential and shared only with the professionals involved in evaluating my eligibility. I hereby certify, under penalty of perjury, that the information submitted is true and correct. I understand that providing any false information on this application may constitute a crime punishable under the law. Further, I understand that providing false or misleading information could result in the denial of my application or termination of my eligibility.

I give permission for MTA Mobility Certification staff to contact the professional who has filled out this application or given supplemental verification of my condition.

Applicant Signature: ___________________________ Date: ___________________________

If someone other than the applicant has completed this form, please provide the following information:

Print Name: ___________________________ Relationship to Applicant: ______________________

Agency (if applicable): ___________________________

Phone Number: ___________________________ Other Phone Number: ______________________

Signature: ___________________________ Date: ___________________________

**Original Signatures Required**
Part B: Healthcare Professional Certification (*please print*)

Licensed or certified healthcare professionals authorized to fill out this certification include, but are not limited to the following:

- Vocational Rehabilitation Counselor
- Physician
- Licensed Clinical Social Worker
- Physician’s Assistant
- Respiratory Therapist
- Nurse Practitioner
- Occupational Therapist
- Psychiatrist/Psychiatric Social Worker
- Physical Therapist
- Ophthalmologist
- Audiologist
- Optometrist
- Independent Living Specialist
- Psychologist
- Speech and Language Pathologist

The Americans with Disabilities Act (ADA) requires transit systems that operate fixed route service to offer complementary paratransit to people with disabilities who cannot use the MTA fixed route service. In accordance with the ADA, the MTA offers MTA Mobility, a door-to-door, shared ride service for those who cannot use the fixed route service because of their disability.

The following factors do not, by themselves, qualify a person for ADA paratransit:

- Diagnosis
- Distance to bus stop
- Lack of bus service
- Inability to drive
- Age
- Inconvenience
- Personal finances
- Discomfort

Please be advised that all of MTA’s buses and rail services are lift/ramp equipped, have wheelchair securement areas, priority seating areas for people with disabilities, and provide audio route and stop announcements.

MTA bases eligibility determinations on the information provided by the applicant in the application and in the interview, observations made during the functional assessment, if used, and information provided by the healthcare professional.

An incomplete application will be returned to the applicant and may delay processing. Every question **must** be answered and must be legible. Please attach supplemental documentation if additional space is required to thoroughly answer all questions.
Applicant Name: ________________________________  Applicant Sex: □ Male □ Female

Healthcare Professional Name: ________________________________

Title: ________________________________

License Number: ____________________________  State Issued: ______________

Institution/Facility/Agency: _______________________________________

Street Address: _______________________________________

City/State/Zip Code: _______________________________________

Phone Number: ____________________________  Fax Number: ___________________

Email Address: _______________________________________

In the following questions, please focus on the applicant’s functional abilities.

1. Written diagnosis(es) and ICD-10 and/or DSM Code(s):

________________________________________________________________________

2. How long have you been treating the applicant?

________________________________________________________________________

3. When was the last time you saw the patient?

________________________________________________________________________

4. What is the expected duration of the disability?

□ Short Term  □ Long Term

*Short Term: Conditions likely to improve within one year
*Long Term: Conditions with little expectation of improvement

5. How does the disability or health condition impact the applicant’s ability to travel independently on MTA fixed route services?

________________________________________________________________________

6. Check all of the mobility devices that the applicant requires:

□ Cane  □ Braces  □ Crutches  □ Walker

□ White Cane  □ Manual Wheelchair  □ Wheelchair  □ Service Animal

□ Scooter  □ Respirator/Oxygen

________________________________________________________________________
7. Is the applicant currently on any medications with side effects that may significantly reduce/hinder their ability to independently ride the accessible MTA fixed route service?  
   If yes, please list the medications:  
   □ Yes  □ No  

8. Does the applicant have a seizure disorder?  
   □ Y  □ N  □ N/A

9. Are the seizures controlled with medication?  
   □ Y  □ N  □ N/A

10. Date of the last seizure:  

11. Does the applicant have a cognitive impairment?  
   □ Y  □ N  □ N/A  
   Please explain:  

For the following questions (12-17), check Yes (Y), No (N), or Sometimes (S). If you answer yes or sometimes, please explain how it prevents the applicant from using accessible MTA buses and trains.

12. Does the applicant have any challenges with memory?  
   □ Y  □ N  □ S  
   Please explain:  

13. Would the applicant be able to recognize and avoid dangers when traveling alone in the community?  
   □ Y  □ N  □ S  
   Please explain:  

14. Would the applicant be able to independently seek assistance if they were lost in the community?  
   □ Y  □ N  □ S  
   Please explain:  

15. Would temperature extremes affect the applicant’s ability to ride transit?  
   □ Y  □ N  □ S  
   Please explain:  

16. Would ice and/or snow affect the applicant’s ability to ride transit?  
   □ Y  □ N  □ S  
   Please explain:  

17. Would poor air quality affect the applicant’s ability to ride transit?  
   □ Y  □ N  □ S  
   Please explain:  

18. Does the applicant have any challenges with balance?  
   □ Y  □ N  □ S  
   Please explain:  

______________________________________________

This page to be completed by health care provider only
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19. Does the applicant have a psychiatric condition that may impact functional ability?  
Please explain: 

20. Does the applicant have any challenges with breathing?  
Please explain: 

21. Does the applicant have any challenges with strength and endurance?  
Please explain: 

22. Does the applicant have any challenges with ambulating on hills?  
Please explain: 

23. Are there any visual impairments that would affect this applicant's ability to ride transit?  
Please explain: 

24. Are there any hearing impairments that would affect this applicant’s ability to ride transit?  
Please explain: 

25. Does the applicant exhibit any inappropriate social behaviors?  
Please explain: 

26. Do you have safety concerns for this applicant in using the fixed route service independently?  
Please explain: 

27. Does the applicant require a Personal Care Attendant while traveling or at their destination?  
Please explain: 

28. In your medical opinion, what other factors related to the applicant’s disability(ies) affect their ability to ride MTA fixed route service?  

Certification  
I certify that I am licensed/certified and am currently treating ______________________________.  
I certify that all information provided in this application is a fair representation of the applicant’s disability(ies) or health condition(s) and is true and correct.  

I understand that the information provided will be used for the purpose of determining the applicant’s eligibility for ADA paratransit service.  

I agree that MTA and its eligibility contractor may contact me for clarification of any information I have provided and that I will reply with good faith.
Please Note:

- Applicant interview must take place within 60 days of the completion of Part B.
- Applicants must present the original form in person at their interview appointment. Please do not mail this form to Certification.

**Original Signatures Required**