**Important Notice to Applicants Regarding COVID-19 Modified Procedures**

Dear Applicant,

During the COVID-19 State of Emergency, MobilityLink will not be receiving customers for appointments in our office. Applications should be sent to the MTA Mobility Office using one of the below options. Our team will contact you to schedule a phone interview, once we received your completed application (Part A & B). Original Signatures are not required at this time.

**Option 1:** Once completed, please mail to: ATTN: MobilityLink Certification Office 1st Floor, 4201 Patterson Avenue, Baltimore, MD 21215

**Option 2:** Please fax your completed application to (410) 764-7526.

**Option 3:** Please email your completed application to MTACertification@mdot.maryland.gov.

If you would like to register to vote electronically in person at the Mobility Certification Office, please contact the number below and transportation can be provided to the Certification Office after the state of emergency has concluded.

We apologize for any inconvenience this change may cause, and we look forward to serving you in person when it is safe to do so. If you have any questions or concerns, please contact the MobilityLink Certification Office at 410-764-8181 Option 6.

Thank you,

MTA MobilityLink Certification Office
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, return the application to the MTA by one of the following methods:
   Option 1: Once completed, please mail to: ATTN: MobilityLink Certification Office 1st Floor, 4201 Patterson Ave., Baltimore, MD 21215
   Option 2: Please fax your completed application to (410) 764-7526
   Option 3: Please email your completed application to:
   MTACertification@mdot.maryland.gov
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.
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?  
   \[ \square A \quad \square S \quad \square N \]
   If Sometimes or Never, please explain: ________________________

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

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

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

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

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

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

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

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?  
   \[ \square Yes \quad \square No \]

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

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

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: ________________________________
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    □ Motorized Wheelchair
   □ Scooter    □ Respirator/Oxygen

This page to be completed by health care provider only
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 (12-27), 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: ________________________________________
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?  
   Please explain: 

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.
Signature: ________________________________  Date: ________________

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.
VOTER REGISTRATION INFORMATION

If you are not registered to vote where you live now, would you like to apply to register to vote? If you do not check either box, you will be considered to have decided not to register to vote at this time.

☐ Yes ☐ No

You can register online at [www.vote.org/register-to-vote/maryland/](http://www.vote.org/register-to-vote/maryland/) or in person in our Certification Office.

If your answer is yes, a voter registration application is enclosed with the MTA MobilityLink Application. You may complete the enclosed voter registration application and send it to MTA MobilityLink. MTA will transmit it to the appropriate election board. You may also send the voter registration form to the appropriate State election official yourself. You can also register online at [www.vote.org/register-to-vote/maryland/](http://www.vote.org/register-to-vote/maryland/) or in person at the MTA MobilityLink Certification Office. If you would like to register to vote electronically in person at the Mobility Certification Office, please contact the number below and transportation can be provided to the Certification Office after the State of Emergency has concluded.

When you complete a voter registration application, if you do not select a political party affiliation, you will be designated as not affiliated with a political party and will be unable to vote in a party primary election.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by MTA. If you would like help in filling out the voter registration application form, MTA will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Please contact MTA MobilityLink at (410) 764-8181 Option 6 for assistance with voter registration.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the State Board of Elections.

Maryland State Board of Elections
P.O. Box 6468
Annapolis, Maryland 21401-0486
800-222-8683

Your application for MTA MobilityLink services may not be completed until you have indicated whether you wish to register to vote. Therefore, please indicate whether you would like to register to vote or decline to register above.
TO REGISTER, YOU MUST
- Be a U.S. citizen;
- Be a Maryland resident;
- Be at least 16 years old*;
- Not be under guardianship for mental disability or if you are, you have not been found by a court to be unable to communicate a desire to vote;
- Not have been convicted of buying or selling votes;
- Not have been convicted of a felony, or if you have, you have completed serving a court-ordered sentence of imprisonment.
*You may register to vote if you are at least 16 years old but cannot vote unless you will be at least 18 years old by the next general election.

DEADLINE INFORMATION
- This application must be postmarked no later than 21 days before an election.
- If your application is complete and you are found to be qualified, a Voter Notification Card will be mailed to you.
- The submission of this form to an individual other than an official, employee, or agent of a County Board of Elections does not assure that the form will be submitted or filed in a timely manner.

YOU CAN USE THIS FORM TO
- Register to vote in federal, state, county, and municipal elections in Maryland.
- Change your name, address, or party affiliation.

INSTRUCTIONS
- If you do not have a current, valid Maryland driver’s license or MVA ID card, you must enter the last 4 digits of your social security number. The statutory authority allowing officials to request the last 4 digits of your social security number is Election Law Article, § 3-202. The number will only be used for registration and other administrative purposes. It will be kept confidential.
- Complete Items 1–11 in Voter Registration Application. Sign and date Item 12. If you are registered to vote in another Maryland county or another state, you must complete Items A–B in Last Voter Registration.
- You must register with a party if you want to take part in that party’s primary election, caucus or convention. Check one box only.
- Detach this panel at the perforation.
- Address and mail the application to your County Board of Elections, using the list on the back panel.

WARNING
Giving false information on an application for voter registration is perjury, punishable by imprisonment for up to 10 years, and a violation of the election laws, punishable by a fine of up to $1,000, or by imprisonment for up to 5 years, or both.

PERSONAL RECORDS NOTICE/CONFIDENTIALITY
This form collects personal information for voter registration purposes. If you are not registered to vote and you refuse to provide this information, you will not be allowed to vote in Maryland. You may update your voter registration at any time at your County Board of Elections. Except for items specified as confidential, voter registration records are generally available for public inspection; they may also be shared with jury commissioners/clerks or other government agencies as provided by law. The law prohibits use of voter registration records for commercial solicitation purposes. If you decline to register to vote, that fact will remain confidential and will be used only for voter registration purposes.

If you register to vote, the identity of the office at which the application is submitted will remain confidential and will be used only for voter registration purposes.

The Maryland Safe at Home Address Confidentiality Program (ACP) is administered by the Office of the Secretary of State and provides an important service to victims of domestic violence and human trafficking. For more information about this Program please call 1-800-633-9657, ext. 3875.

QUESTIONS
Visit the State Board of Elections website at www.elections.maryland.gov to verify your registration, find your polling place, and find out other important information. If you have any questions, call your County Board of Elections or the State Board of Elections at the numbers listed on the back of the application.

Large type Voter Registration Applications available upon request to your County Board of Elections or the State Board of Elections.
Are you at least 16 years old?  □ Yes  □ No

ARE YOU A U.S. CITIZEN?  □ Yes  □ No

If you answer NO to either question, do not complete this form.

Check boxes that apply and complete Items 3–12.

□ New Registration  □ Name Change  □ Party Affiliation Change  □ Address Change

Last Name     First Name     Middle     Suffix

Gender:  □ Male  □ Female  □ Unspecified or Other

Month       Date       Year

Birth Date:

MARYLAND Driver’s License or MVA ID Number MANDATORY (if you have neither see instructions)

Social Security Number (last 4 digits)

□ Check here if you do not have either a current, valid Maryland driver’s license / MVA ID card or a Social Security Number

Maryland Street Number               Street Name               Apt. No.               City or Town               Zip Code               County

Residence Address:

Check here if you reside in Baltimore City.

Mailing Address (if different from Item 7)

You must register with a political party if you want to take part in the political party’s primary election, caucus, or convention. Check one box only.

Party (check one):  □ Democratic Party  □ Republican Party  □ Bread and Roses Party  □ Working Class Party  □ Unaffiliated (independent of any party)  □ Other – Specify ________________________________

CONTACT INFORMATION

Daytime Phone: Email (optional):

☐ Check here if you need help voting.

☐ Check here if you would like to be an election judge.

Under penalty of perjury, I hereby swear or affirm: I am a U.S. citizen. □ I am a Maryland resident. □ I am at least 16 years old. □ I have not been convicted of buying or selling votes. □ I have not been convicted of a felony, or if I have, I have completed serving a court-ordered sentence of imprisonment. The information in this application is true to the best of my knowledge, information and belief.

Signature (required)  Date

LAST VOTER REGISTRATION INFORMATION (if applicable)

A  Name on Last Registration:  Last Name  Title (Jr., Sr., etc.)  First Name  Middle Name  Date of Birth

B  Address on Last Registration:  Street Number  Street Name  Apt. No.  City or Town  Zip Code  State

State Board of Elections  •  P.O. Box 6486  •  Annapolis, MD 21401-0486  •  www.elections.maryland.gov  •  800-222-8683  •  MD Relay Service (800) 735-2258
County Board of Elections

Applicant's Return Address

----------------------

Fold here and close with adhesive strip to mail.
To:


County Board of Elections