

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. MTA Mobility will provide you with instructions on how to request a ride during this period.

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? A S N
If Sometimes or Never, please explain: _____
2. Cross the street? A S N
If Sometimes or Never, please explain: _____
3. Stand for 20 minutes if there is no place to sit? A S N
If Sometimes or Never, please explain: _____
4. Step on and off a sidewalk from a curb? A S N
If Sometimes or Never, please explain: _____
5. Walk on uneven surfaces? A S N
If Never, please explain: _____
6. Stand on a moving bus or train if there is a handrail? A S N
If Never, please explain: _____
7. Transfer from one bus or train to another? A S N
If Never, please explain: _____
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:

- | | | | |
|-------------------------------------|--|---|---|
| <input type="checkbox"/> Cane | <input type="checkbox"/> Braces | <input type="checkbox"/> Crutches | <input type="checkbox"/> Walker |
| <input type="checkbox"/> White Cane | <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Motorized Wheelchair | <input type="checkbox"/> Service Animal |
| <input type="checkbox"/> Scooter | <input type="checkbox"/> Respirator/Oxygen | <input type="checkbox"/> Other: _____ | |

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?

Yes No *If yes, please list the medications:* _____

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? Y N S
- Please explain:* _____
20. Does the applicant have any challenges with breathing? Y N S
- Please explain:* _____
21. Does the applicant have any challenges with strength and endurance? Y N S
- Please explain:* _____
22. Does the applicant have any challenges with ambulating on hills? Y N S
- Please explain:* _____
23. Are there any visual impairments that would affect this applicant's ability to ride transit? Y N S
- Please explain:* _____
24. Are there any hearing impairments that would affect this applicant's ability to ride transit? Y N S
- Please explain:* _____

This page to be completed by health care provider only

25. Does the applicant exhibit any inappropriate social behaviors? Y N S

Please explain: _____

26. Do you have safety concerns for this applicant in using the fixed route service independently? Y N S

Please explain: _____

27. Does the applicant require a Personal Care Attendant while traveling or at their destination? Y N S

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.

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.

****Original Signatures Required****