



1900 Main
P.O.Box 61429 Houston, TX
77208-1429
Fax: 713-739-4971

Client ID # _____
Date Entered _____
Processed by _____

Application for METROLift Service

Instructions: On pages one (1) through four (4) of this application, METROLift is asking for information about you and your ability to use METRO bus service. Please take the time to answer EVERY question carefully and completely. A friend, guardian, caregiver, agency service representative or family member may help you complete your portion of the application (pages one (1) through four (4)). Accurate information is required about you, your medical impairment, and your functional capacity. Pages five (5) through six (6) must be completed and certified by a physician/certified health professional who is familiar with your impairment or condition. Both the eligibility form and the doctor's additional signature must be submitted to METROLift for processing. Failure to do so will delay the processing of your application.

If you have questions, please call METROLift Customer Service at 713-225-0119.

Have you ever applied for METROLift? No Yes

TO BE COMPLETED BY APPLICANT

First Name	Last Name	Middle Name	Email	
Date of Birth (MM/DD/YYYY)		Home Phone Number		Mobile Number
Address		Apartment Number	City	Zip Code
Apartment Complex Name				Gate Code
Mailing Address If different from home address		City	State	Zip Code
Applicant Signature (required) X _____			Date _____	

Name of Emergency Contact	Relationship	Emergency Mobile Phone
_____	_____	_____

Individual and Mobility Information

1. Please state your disability or disabilities.

2. What assistive device(s) do you use when traveling? (Please check all that apply.)

- | | | |
|---|---|---|
| <input type="checkbox"/> Support cane | <input type="checkbox"/> Manual wheelchair | <input type="checkbox"/> Trained service animal |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Powered wheelchair | <input type="checkbox"/> Communications device |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Power scooter | <input type="checkbox"/> "White cane" |
| <input type="checkbox"/> Leg brace(s) | <input type="checkbox"/> Portable oxygen | <input type="checkbox"/> None |
| <input type="checkbox"/> Other (describe) _____ | | |

3. What is the nearest street intersection to your home? (Example: Polk & Wayside)

4. Can you walk or use your wheelchair or assistive device(s) from your home to that intersection without assistance? Yes No

If "no," please explain. _____

5. Can you find your way to a bus stop without getting lost? Yes No

If "no," please explain. _____

6. How long can you stand and wait for a bus?

- 15 minutes 10 minutes 5 minutes Less than 5 minutes

7. All buses have a "destination sign" in front, which shows the route name and number.

Can you read a bus destination sign? Yes No

Can you ask the driver where the bus is going? Yes No

Can you give or write a note to the driver? Yes No

Can you understand the driver's answer? Yes No

If "no" to any questions, please explain.

8. If you were on the bus, could you pay the fare by putting money in the fare box, or by tapping the METRO Q Card on the Q box? Yes No

If "no" please explain _____

9. If you were on the bus, could you recognize the place where you wanted to get off the bus?
Yes No

If "no," please explain. _____

10. Please tell us about the times when you can use METRO's local fixed-route bus service?
(Example: if short distance to bus stop; take attendant; need to get somewhere.)

11. Have you ever received "orientation and mobility training" or "travel training?" Yes No

If "yes," please list any METRO bus routes on which you can travel:

12. Please tell us the reasons you feel you cannot use METRO's local fixed-route bus service for some or all trips.

13. How do you currently travel (self, family, friends, bus, rail, METROLift, etc.)?

Please explain. _____

14. Do you require someone to travel with you? Yes No

If "yes," please explain _____

15. Can you wait independently alone at your residence and places to which you travel?

Yes No

If "no," please explain. _____

Agreement and Authorization:

I state that the information I have provided is true and accurate.

I authorize the release of diagnostic and functional information as requested on pages five (5) and six (6) to METRO for the sole purpose of making a determination regarding my eligibility for paratransit service (METROLift) and understand that personal and medical information will be kept confidential.

I understand that intentionally providing false or misleading information or refusal to undergo an in-person interview assessment is grounds for denial of METROLift services.

If approved, I agree to follow the rules and guidelines established by METROLift and to promptly inform METROLift of any changes in my residence, phone number and, if applicable, my representative's name and phone number; and any significant change in my condition that would affect my level of mobility.

I understand that failure to follow proper procedures or cooperate with METROLift staff, demonstrating illegal or disruptive behavior or, if my condition at any time poses a direct threat to the health or safety of others, such situations may result in either suspension and/or termination of service.

Applicant's Signature:

Date:

If someone other than the applicant is preparing this form, please provide the following information about the preparer:

Name: (please print) _____

Mobile Phone: _____ Relationship: _____

Preparer's Signature: _____ Date: _____



METROLift News and Updates

Visit RideMETRO.org/METROLiftNews or scan the QR code to receive the latest METROLift news and information, including holiday hours, weather updates and more.

Patient's Name: (please print) _____
 Date of Birth: _____ Mobile No.: _____
 Address: _____

THE FOLLOWING FORM MUST BE COMPLETED BY YOUR DOCTOR.

We need your assistance in determining eligibility for services provided by METROLift to persons with disabilities who are unable to use local bus transportation. We are seeking specific information as to what prevents the person from using METRORail and the METRO bus routes that provide transportation throughout the area. METRO buses are equipped with ramps, lifts, and kneeling features to assist boarding as well as automatic announcements of major stops to help riders know where they are along the route. The Americans with Disabilities Act of 1990, 49 CFR 37.121, Subpart F states – "...each public entity operating a fixed route system shall provide paratransit or other special service to individuals with disabilities that is comparable to the level of service provided to individuals without disabilities who use the fixed-route system". By complementary, Department of Transportation (DOT) means service for individuals with disabilities who cannot use the fixed route bus system. The information requested of you in the following sections will be used to help determine the applicant's METROLift eligibility. It is important that all questions be answered completely and accurately to the best of your knowledge and in accordance with your records. If the information is incomplete or unclear, we may need to contact you for clarification. Thank you for your cooperation.

1. Have you previously seen this patient? Yes No

2. Please rate (Excellent / Good / Fair / Poor / None / Don't Know) the applicant in terms of:

	Excellent	Good	Fair	Poor	None	Don't Know
a. Upper body strength	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Lower body strength	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Coordination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Balance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Self awareness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Independent judgment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Sense of direction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Ability to understand and follow instructions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Verbal communication	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Written communication	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Stamina and endurance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. In your opinion, can the applicant travel independently from his/her house to the sidewalk?

Yes No Sometimes

If "no" or "sometimes," please explain. _____

4. Can the applicant walk up and down two steps? Yes No Sometimes

5. Assuming the use of a mobility aid, if applicable, and with no major barriers in his/her path, how far can the applicant independently travel without assistance?

less than 1/4 mile 1/4 mile 1/2 mile 3/4 mile more than 3/4 mile

6. Does the applicant's disability require him/her to travel with another person who provides personal assistance? Yes No Sometimes
7. Please provide medical diagnoses in layman's terms to describe the applicant's primary impairments or disabling conditions.
- _____
- _____
8. What specific information describes what prevents your patient from accessing the local bus and rail system?
- _____
- _____
9. Is the condition Permanent or Temporary (months) _____
10. If visually impaired, what is the applicant's best corrected acuity?
 (Snellen Test)? (R) _____ (L) _____
 Field Restriction: (R) _____ (L) _____ Date of Testing: _____
11. If cognitively impaired, what is the applicant's cognitive age, and IQ level?
- _____
12. Is the applicant a wheelchair user? Yes No If yes, how often _____
13. Does the applicant use other mobility aids? Yes No If yes, please describe.
- _____
- _____

Physician or Health Care Professional's Certification

I certify that the information I have provided herein is a fair representation of this applicant's medical impairment or condition and is accurate to the best of my knowledge. I understand that the information provided herein will be used for the sole purpose of determining the applicant's eligibility for paratransit services. I also agree that METROLift may contact me for clarification of any information I have provided and that I will reply in good faith.

Physician / Health Professional Name _____

Institution / Facility / Agency Name _____

Street Address _____ Suite # _____

City _____ State _____ Zip Code _____

Medical / Social Worker's License Number _____ Telephone # _____ Fax # _____

Physician's / Health Professional's Signature _____ Date _____

*****Note: Additional signature of physician / healthcare professional on his / her letterhead or prescription verifying completion of application is required.**