2424 Piedmont Rd. N.E.
Atlanta, GA 30324-3330
404-848-5000

SUBJECT: **APPLICATION FOR MOBILITY PARATRANSIT ELIGIBILITY**

Dear Applicant:

The Metropolitan Atlanta Rapid Transit Authority (MARTA) appreciates your interest in our Mobility Paratransit Services. The Americans with Disabilities Act of 1990 (ADA) requires MARTA to provide equivalent public transportation to individuals with disabilities who cannot board, ride, or get to an accessible fixed route bus or train due to their disabilities. This service must be comparable to the service that is provided to individuals without disabilities who use MARTA's regular fixed-route system.

If you have a current diagnosed disability that prevents you from using a MARTA lift-equipped bus or the accessible rail system, you may be eligible for Mobility Paratransit Services. If your disability does not prevent you from using a lift-equipped bus or the accessible rail system, you may take advantage of MARTA's **Reduced Fare** program for individuals with disabilities. The card allows you to travel at half the regular fare (currently, $1.00 one-way) on both the bus and rail system. (Alternatively, the Mobility fare is $4.00 each way.) The **Reduced-Fare Office** number is (404) 848-5112. MARTA provides assistance with navigating the Fixed Route system through a free **Travel Training Program**. For information about this free service, please contact the **Travel Training Office** at 404-848-6020.

Enclosed you will find **PART A** of the Application for MARTA Mobility. **YOU OR YOUR DESIGNEE MUST COMPLETE ALL QUESTIONS and you must sign it to certify that the information is complete and correct.** Please be sure that **all** of the **signatures** required on the **Authorization** page have been **signed** by you or your designee.

Please forward **PART B** of this application to your Health Care Professional. **PART B must be completed and signed** by your Health Care Professional. You must return **both PART A and PART B** of the application to MARTA Failure to return fully completed PART A and PART B of the application will delay processing. Once MARTA has received your completed PART A and PART B of the application, you will be contact by MARTA Mobility Eligibility to schedule your in person interview and possible assessment. **Upon completion of your assessment you will receive Presumptive Eligibility to ride MARTA Mobility if the eligibility determination**

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is not made within 21 calendar days of completion of your interview and possible assessment.

Please return your application in the enclosed envelope.

If you have any questions, please call the MARTA Mobility Eligibility Department at (404) 848-5389 (Voice) or -711 (Georgia Relay for Hearing Impaired).

Alternative Format available upon request:
_____ Large Print (Font Size) _____
_____ CD
_____ Language (other than English) _____
_____ Braille

MARTA MOBILITY PARATRANSIT ELIGIBILITY APPLICATION FOR CERTIFICATION

PART A

DEAR APPLICANT:

This application for certification is the first step in the process that will be used to determine your eligibility for MARTA Mobility Paratransit Services. MARTA Mobility Paratransit Service is an origin to destination public transportation service for individuals with disabilities who are prevented from using MARTA's Fixed Route transportation services. MARTA's Fixed Route services include bus and rail transit services. MARTA's bus and rail services are fully accessible to individuals with disabilities. MARTA's Mobility Paratransit Services and Fixed Route Services operate in Fulton, Dekalb and Clayton Counties and in the City of Atlanta.

Please be sure to do the following:

- You must complete the entire PART A of the application and answer every question.
- Incomplete applications cannot be processed and will be returned.
- You must have PART B completed by your Health Care Professional who can appropriately answer questions about your disability and ability to travel.
- You must return both PART A and PART B as the first step of the Certification Process.
- Please be sure that both PART A and PART B are completed and signed before returning.

Your application is complete once you return Both PART A and PART B to MARTA.

SECTION 1 - APPLICANT GENERAL INFORMATION (PLEASE PRINT)

New Applicant ☐ **Re-certification Applicant ☐**

If re-certifying, please provide MARTA Mobility Breeze Card Number_____

Last Name _____ **First Name**_____ MI_____ **Title**____

Street Address: _____

City_____ **State**_____ **Zip**_____ **County**_____

Subdivision/Apartment Complex Name/Gate Code: _____

Nearest major intersecting street: _____

Cell Phone #_____ **Home Phone #**_____ **Work #**_____

SS # _____ **DOB:** _____

Providing the above information is optional and it will be for ID purposes only.

SECTION 2 – INFORMATION ON DISABILITY & MOBILITY EQUIPMENT

Please be sure to complete ALL of the below information

Please list by name the disabilities or health related conditions which prevent you from using MARTA's Fixed Route Bus and Rail Services:

Is this condition temporary? Yes ☐ No ☐ if yes, how long do you anticipate your disability will affect you?

How does this condition affect your ability to ride regular fixed route bus and train service?

Do any of the following conditions affect your travel?

Hills _____ No Curb Cut _____ No Sidewalk _____

Do you use a mobility device to travel? Please check all that apply:

_____ **White cane**
_____ **Orthopedic cane (three or four prong base)**
_____ **Walker**
_____ **Braces**
_____ **Crutches**
_____ **Manual Wheelchair**
_____ **Motorized Wheelchair**
_____ **Scooter**

Do you use a service animal? Yes ☐ No ☐ if yes, what type of animal and for what purpose was the animal trained?

Do you travel with portable medical equipment? Yes ☐ No ☐
What type of equipment?

Do you require someone to travel with you to provide personal transportation assistance? Yes ☐ No ☐ Sometimes ☐

How do you currently travel?

Have you ever been trained in the use of MARTA's bus and rail system?
Yes ☐ No ☐
If yes, **where?** _____

Do you feel that you could ride the train or bus if the van could get you there and pick you up from there? _____

To the best of my knowledge, the information I have provided in **PART A** of this application has been properly recorded. I have reviewed all answers and certify that the information is complete and correct. I understand that any intentional false or misleading information may be grounds for denial of service.
Signature of applicant_____ date_____/_____/_____
Representative or legal guardian

- **Please remember that both PART A and PART B are to be completed and signed returned together.**

<u>In case of emergency contact</u> (if possible, alternative number, other than your home phone):

Name_____ **Phone #**_____

If this application has been completed by someone other than the applicant, that person **must** complete the following:

Name_____ **Relationship**_____

Address_____

Home phone_____**work**_____**tdd/tty**_____

I certify, to the best of my knowledge, that the information provided in this application is complete and correct based upon the information given me by the applicant or my own knowledge of the applicant's health condition or disability.

Signature_____
date_____/_____/_____

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Dear Health Care Professional:

The Americans with Disabilities Act (ADA) of 1990 is a civil rights bill which prohibits discrimination against persons with disabilities. In accordance, MARTA is required to provide comparable (paratransit) transportation for individuals who, because of their disability, cannot travel by fixed route (bus or rail) service. MARTA's regular bus and rail service is wheelchair accessible and operators make the required ADA announcements to assist the visually impaired. Many disabled individuals use our system daily; however, a percentage of patrons cannot travel on regular buses or the rail system. Individual categories applying to these patrons are described below.

One of your clients has requested certification for use of MARTA Mobility Services. Your assistance is required for evaluating and properly determining the applicant's ability or inability to use MARTA's regular bus and/or rail service. Please complete the attached Health Care Professional Certification (**Part B**) of the Application for MARTA Mobility Services and return to your client.

The law specifically defines the conditions of eligibility for paratransit (MARTA Mobility) transportation. We hope that the descriptions below will aid your understanding of the eligibility criteria. The three categories of eligibility are defined as follows:

Category 1: Individuals with disabilities who cannot board, ride or disembark from an accessible vehicle (e.g., people who, because of a visual or cognitive impairment, could never "navigate the system"). These individuals are usually paratransit dependent for life.

Category 2: Individuals with disabilities who <u>can</u> use an accessible vehicle (bus or rail) but an accessible vehicle is not available. These individuals are usually transitional users until the system becomes 100% accessible.

Category 3: Individuals with disabilities who have specific impairment related conditions which prevent them from getting to and from a bus stop. A combination of a disability and environmental barriers (such as a blind person who cannot cross an eight lane highway or a wheelchair user who cannot go up a steep hill or push through heavy snow) may prevent a person from getting to and from a stop. The existence of a barrier alone, however, does not confer eligibility. Inconvenience and decreased comfort are not a basis for qualification. The condition must <u>prevent</u> the travel.

Should you need additional information or explanation, please call our MARTA Mobility Paratransit Eligibility Office at (404) 848-5389.

MARTA MOBILITY PARATRANSIT ELIGIBILITY
HEALTH CARE PROFESSIONAL CERTIFICATION

PART B

DEAR APPLICANT:

PART B must be completed by one of the following licensed Health Care Professionals:

- Physician
- Registered Nurse
- Social Worker
- Psychologist
- Physical Therapist
- Chiropractor
- Occupational Therapist
- Special Education Teacher
- Nurse Practitioner
- Physician's Assistant
- Mental Health Counselor
- Orientation/Mobility Specialist
- Vocational Rehabilitation Counselor
- Respiratory Therapist
- Speech Pathologist
- Recreation Therapist (employed by a medical facility)

Name of Applicant:_____

Capacity in which you know the applicant: _____

Date of applicant's last visit: _____

Medical diagnosis of disability: _____

_____

Please describe the impact this disability has on the applicant's ability to function:

_____

_____

_____

Is the disability/condition permanent: YES ☐ NO ☐

If temporary, when will applicant be able to resume normal travel patterns:

Date: _____

Is disability/condition periodic: YES ☐ NO ☐

If yes, under what circumstances does disability/condition flare-up: _____

_____

_____

Does the applicant have the mental capacity, visual and/or hearing ability to:

Give addresses and phone number:	YES ☐	NO ☐
Recognize a destination or landmark:	YES ☐	NO ☐
Deal with unexpected change in route:	YES ☐	NO ☐
Ask for, understand and follow directions:	YES ☐	NO ☐
Safely/effectively travel through crowded/complex facilities:	YES ☐	NO ☐

Are there any other mobility concerns of which MARTA should be aware? If so, please explain: _____

_____

Can the applicant complete the following distance without assistance:

Walk less than a block – approx. 200FT.	YES ☐	NO ☐
Walk the length of 1 football field – approx. 300FT.	YES ☐	NO ☐
Walk the length of 1 football field and back – approx. 600FT.	YES ☐	NO ☐
Walk 1 lap around a track – approx. 1200FT.	YES ☐	NO ☐
Walk up steps – approx. 12-14 inches high	YES ☐	NO ☐
Grip a handrail	YES ☐	NO ☐

Does the applicant use mobility devices? Please check all that apply:

- ☐ White Cane
- ☐ Support Cane
- ☐ Orthopedic Cane (3 or 4 Prong)
- ☐ Walker
- ☐ Braces
- ☐ Crutches
- ☐ Manual Wheelchair
- ☐ Motorized Wheelchair
- ☐ Scooter

Are there any conditions which may prevent the applicant from traveling without assistance on the bus and rail? If so, please explain: _____

_____

_____

Does weather impact applicant's ability to travel: YES ☐ NO ☐

If yes, please explain weather conditions and effects: _____

_____

_____

Does the applicant require a Personal Care Attendant: YES ☐ NO ☐

THIS CERTIFICATION HAS BEEN COMPLETED BY: _____

PRINT NAME OF CERTIFYING PROFESSIONAL: _____

NAME OF FACILITY/AGENCY _____

ADDRESS _____ SUITE _____

CITY _____ STATE _____ ZIP _____

OFFICE PHONE NUMBER _____ FAX _____

GEORGIA STATE LICENSE NUMBER: _____

SIGNATURE _____ CERT. _____ DATE _____